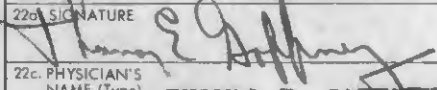
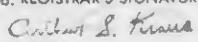


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

2018
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01994

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 11 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY 42X-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jacksonville d. STREET ADDRESS 2304 Forest Hills Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles Mitchell Acres		4. DATE OF DEATH Month Day Year February 17 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 25, 1938
9. AGE (In years, last birthday) 22 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 22	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant		10b. KIND OF BUSINESS OR INDUSTRY Filling Station	
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles O. Acres		14. MOTHER'S MAIDEN NAME Velma Crabtree	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1936-57 413-58-2192	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arrhythmia DUE TO Viral Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) 422.2 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.2		INTERVAL BETWEEN ONSET AND DEATH Unknown 4 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from February 6, 1961 to February 17, 1961 , that (I) (we) last saw the deceased alive on Feb. 17, 1961 , and that death occurred at 6:45 a.m. from the causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 2/17-61	
22c. PHYSICIAN'S NAME (Type) THOMAS E. GAFFNEY, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 2-18-61		23b. DATE THEREOF 2-18-61	
23c. NAME OF CEMETERY OR CREMATORY Restlawn Cemetery		23d. LOCATION (City, town, or county) (State) Jacksonville, Florida	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR Bethesda, Md.	
25b. REGISTRAR'S SIGNATURE 		DATE FEB 21 '61	

(1)

1911

1911

2019

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01995

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Connecticut b. COUNTY V			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 5 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Crawford Last Allen				4. DATE OF DEATH Month February Day 20 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 18, 1926	
9. AGE (In years lost birthday) 35 yrs.		IF UNDER 1 YEAR Months 35 Days 35 Hours 35 Min.		IF UNDER 24 HRS. Months 35 Days 35 Hours 35 Min.			
10a. USUAL OCCUPATION (Give kind of work done) Airlines Station Manager				10b. KIND OF BUSINESS OR INDUSTRY Airlines		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John C. Allen Sr.				14. MOTHER'S MAIDEN NAME Sarah P. Wald			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 047-12-6314		17. INFORMANT The Medical Records The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CNS Metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma, I not known ? Adrenal Glands DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from February 15, 19 61 to February 20, 19 61 , that (I) (we) last saw the deceased alive on February 20 61 and that death occurred at 9:20 p.m. from the causes and on the date stated above.							
22a. SIGNATURE Michael Z. Lazor				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/21/61	
22c. PHYSICIAN'S NAME (Type) MICHAEL Z. LAZOR, M.D.				22d. ADDRESS The Clinical Center National Institutes Of Health Bethesda 14, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/22/61		23c. NAME OF CEMETERY OR CREMATORY Fresh Pond		23d. LOCATION (City, town, or county) (State) Middle Village N.Y.	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. 1400 Chapin St NW				25a. REC'D BY REGISTRAR DATE FEB 23 '61		25b. REGISTRAR'S SIGNATURE Curtis L. Haines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. After death, the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2013

1

2013

CERTIFICATE OF DEATH

Reg. Dist. No. 01996

2020

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DISTRICT OF COLUMBIA</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAKMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM & HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LETCHER</u> Middle <u>CALEB</u> Last <u>ANDERSON</u>				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>20th</u> Year <u>1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 29, 1884</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED-CAR TRANSIT</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James ANDERSON</u>				14. MOTHER'S MAIDEN NAME <u>HARRIET</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>578-10-5488</u>			
				17. INFORMANT Address <u>HOSP. RECORDS-7600 CARROLL AVE.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL PERFORATION</u> <u>420</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>MYOCARDIAL INFARCTION</u> DUE TO (c) <u>ATHEROSCLEROSIS</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u> <u>5 days</u> <u>UNKNOWN</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>FEB 15, 1961</u> to <u>FEB 20, 1961</u> , that I last saw the deceased alive on <u>FEB 19, 1961</u> , and that death occurred at <u>5:20 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Jos. Berkenbilt</u> M.D.				ADDRESS (Street, city or town, state) <u>1025 VERMONT AVE NW</u>			
PHYSICIAN'S NAME (Type) <u>WOS. BERKENBILT</u>				DATE SIGNED <u>WASH. 5 D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-23-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Switland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Horton Funeral Home</u> ADDRESS <u>- 3851 GA Ave.</u>				24a. REC'D BY REGISTRAR <u>FEB 24 '61</u>		24b. REGISTRAR'S SIGNATURE <u>C.W. P.H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2021

01997

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HIGHLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARY LYDIA ANDERSON				4. DATE OF DEATH Month Day Year FEBRUARY 13 19 61			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 25, 1889	
9. AGE (In years lost birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Same		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JOHN SCHAFER				14. MOTHER'S MAIDEN NAME SARAH FRANCES RIDLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. —		17. INFORMANT Address HOSPITAL RECORDS, OLNEY, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE, RIGHT HEMISPHERE 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIAL HYPERTENSION DUE TO (c) 15 YEARS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NEPHROSCLEROSIS							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1948 to FEB. 13, 1961 , that (I) (we) last saw the deceased alive on FEB. 12, 1961 , and that death occurred at 6:20 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Charles S. Whitaker, B. P.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/13/61	
22c. PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M. D.				22d. ADDRESS CLARKSVILLE, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/15/61		23c. NAME OF CEMETERY OR CREMATORY Parkside Chapel		23d. LOCATION (City, town, or county) (State) Baltimore Md	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Donaldson, Laurel, Md				25a. REC'D BY REGISTRAR FEB 20 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

1908

TO THE HONORABLE SECRETARY OF THE
NAVY
WASHINGTON, D. C.
JAN 15 1908
SIR:
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above subject.
The same has been forwarded to the proper authorities for their consideration.
Very respectfully,
J. D. [Signature]
[Title]

RECEIVED
JAN 15 1908
[Signature]
[Title]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2022

01998

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>7 yrs. 2 mo</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. JAN. Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>3701 MASS AVE. Apt 509</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Evelyn</u> First <u>Fant</u> Middle <u>Avery</u> Last			4. DATE OF DEATH Month <u>Feb</u> Day <u>21</u> Year <u>1961</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>7-21-86</u>		9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>			
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u> </u>				
11. BIRTHPLACE (County & State, or foreign country) <u>Ogden, Utah</u>			12. CITIZEN OF WHAT COUNTRY? <u>American</u>				
13. FATHER'S NAME <u>Joseph N. Fant</u>			14. MOTHER'S MAIDEN NAME <u>MARIANA B. Mears</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>			16. SOCIAL SECURITY NO. <u>NONE</u>				
17. INFORMANT <u>Address</u> <u>Jessie F. Evans (Sister)</u> <u>3705 Lowell St. N.W. Wash, DC</u>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage with</u> DUE TO (b) <u>Recurrent</u> (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <u> </u>		20g. (County) <u> </u>		20h. (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>June 2-20-1961</u> to <u>Feb. 21, 1961</u> that (I) (we) last saw the deceased alive on <u>2-20-1961</u> and that death occurred at <u>2:20 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert A. Hare</u>			22b. DATE SIGNED <u>Feb 23 '61</u>				
22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>			22d. ADDRESS <u>7600 Carroll Ave. Tak. Park, Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-25-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CONGRESSIONAL CEMETERY</u>			
23d. LOCATION (City, town or county) <u>WASHINGTON, DC</u>		23e. REC'D BY REGISTRAR DATE <u>FEB 23 '61</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gaudin's Sons, Inc. 1756-Pan Am Bldg N.W.</u>			25. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>				

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: This certificate is to be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2305

(1)

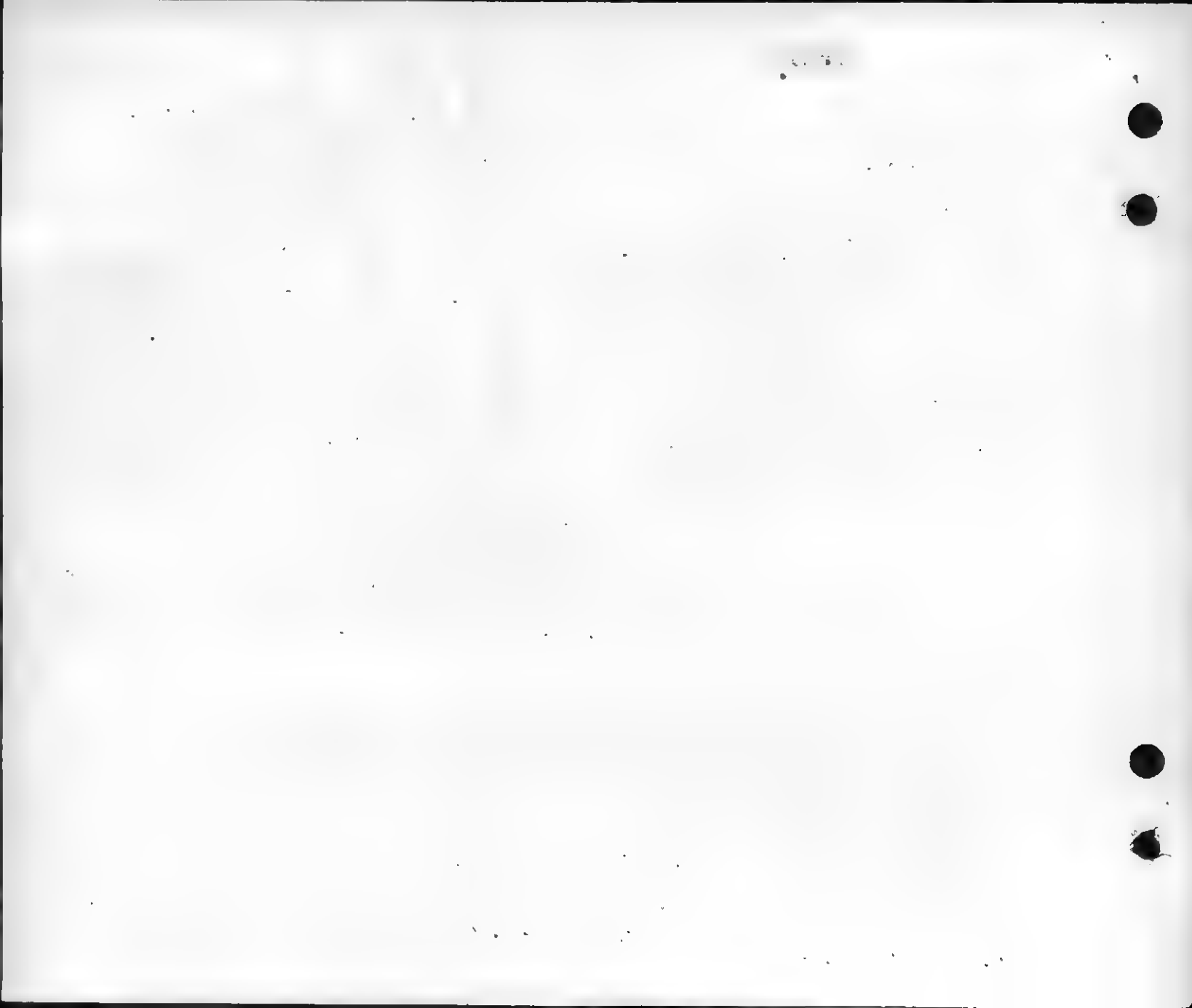
(1)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2023 Item 2 Fil G 1 2-17-61 et
CERTIFICATE OF DEATH

Reg. Dist. No. **01999**

1 PLACE OF DEATH a. COUNTY <u>Maryland</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jan. 1961</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Marylander Rest Home</u>				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>St. Petersburg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Petersburg</u> d. STREET ADDRESS <u>811 Jackson St., Apt. A</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) <u>ELIZABETH H. BABCOCK</u> First Middle Last				4. DATE OF DEATH <u>Feb. 10, 1961</u> Month Day Year					
5 SEX <u>Female</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 2, 1900</u>		9 AGE (In years last birthday) <u>61</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>New Jersey</u>		11. BIRTHPLACE (State or foreign country) <u>US</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Wright Babcock</u>				14. MOTHER'S MAIDEN NAME <u>Adelaide Grinnell</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>Dudley P. Babcock</u> Address <u>4-31 N. O'D D</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>52.6X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Bronchiectasis + Cor Pulmonale</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Rheumatoid Arthritis</u>								INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>4 weeks</u> <u>Indefinite</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/21, 1960</u> , to <u>2/10, 1961</u> that I last saw the deceased alive on <u>2/10, 1961</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Rockville, Md.</u> DATE SIGNED <u>2/10/61</u>									
ACTUAL SIGNATURE <u>Stephen N. Jones</u> M.D.				PHYSICIAN'S NAME (Type) <u>Stephen N. Jones-Rockville, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>2/14/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Trinity</u>		22d. LOCATION (City, town, or county) (State) <u>New York City, New York</u>			
23 FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Hance</u> ADDRESS <u>1400 N. Ave. Rockville, Md.</u>				24a. REC'D BY REGISTRAR <u>FEB 14 '61</u> DATE		24b REGISTRAR'S SIGNATURE <u>Arthur L. Hance</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



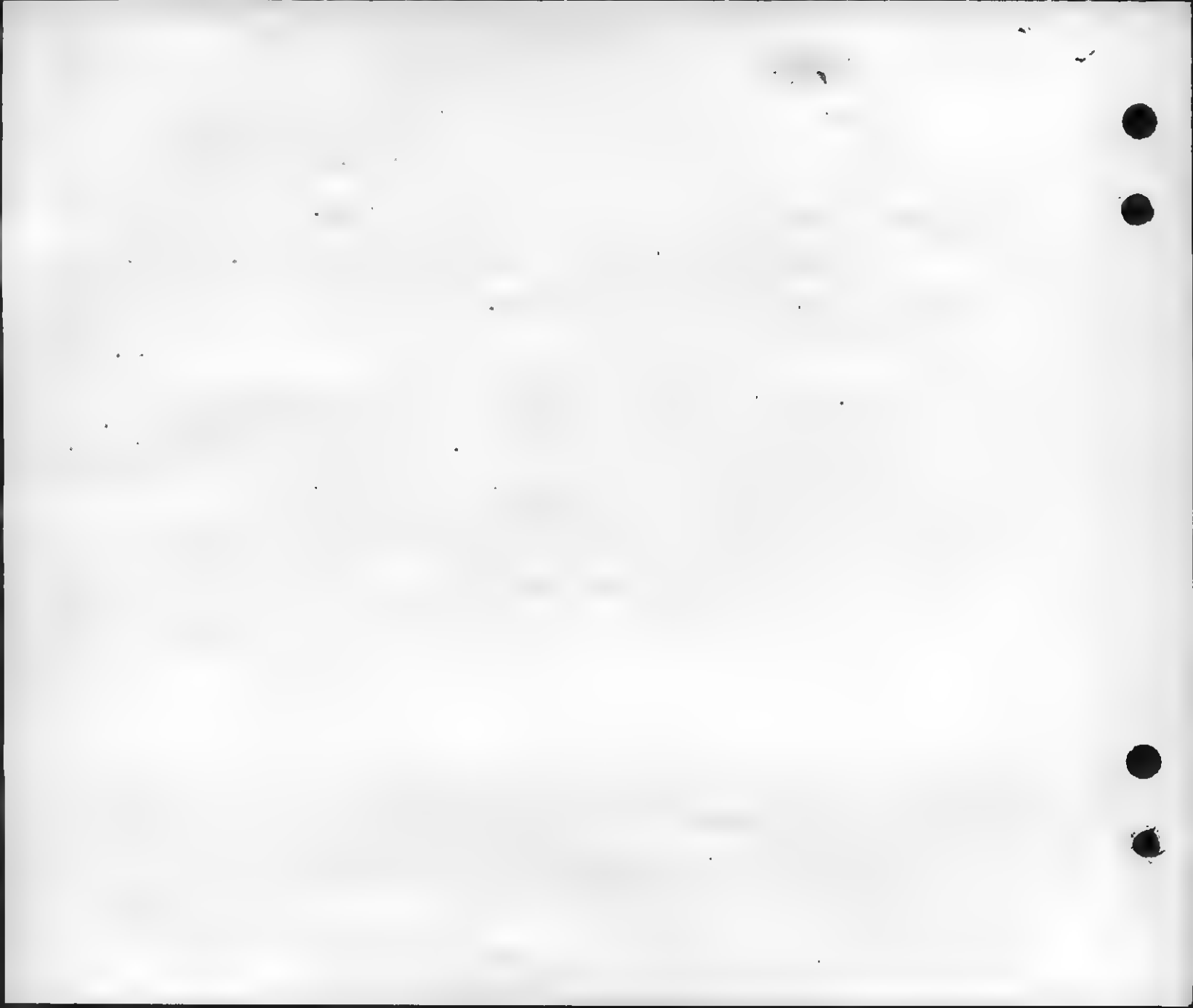
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

2024
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02000

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		2. USUAL RESIDENCE (Where deceased lived. If institut on: Res'dence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg d. STREET ADDRESS 102 Cedar Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Kathleen Last Balzer		4. DATE OF DEATH Month Feb. Day 4, Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 1, 1961
9. AGE (In years lost birthday) yrs. 3		10. IF UNDER 1 YEAR: Months 3 Days 5 Hours 5 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas J. Balzer		14. MOTHER'S MAIDEN NAME Frances Jeanne Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None	
17. INFORMANT Thomas J. Balzer		18. ADDRESS 102 Cedar Ave. Gaithersburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiovascular collapse DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) multiple congenital anomalies DUE TO (c) birth anomalies 3 days 5 hrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) omphalocoel			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/1 1961 to 2/4 1961 , that (I) (we) last saw the deceased alive on 2/3 1961 , and that death occurred at 9:45 AM , from the causes and on the date stated above.			
22a. SIGNATURE Wilfred R. Ehrmentraut		22b. DATE SIGNED 2/4/61	
22c. PHYSICIAN'S NAME (Type) Wilfred R. Ehrmentraut MD		22d. ADDRESS 4890 Battery Lane, Bethesda Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/11/61	
23c. NAME OF CEMETERY OR CREMATORY St. Rosa Cemetery		23d. LOCATION (City, town, or county) (State) Cloppers, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR FEB 14 '61	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	





Arthur S. Kraus

VS. A15ME
5M 7/59



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2027

CERTIFICATE OF DEATH

02003

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>1 hour</u>		d. STREET ADDRESS <u>1411 Aspen Hill Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clarence William Bauer</u>		4. DATE OF DEATH <u>February 27 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 14th 1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retail Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gilson Art Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA XXXXX</u>	
13. FATHER'S NAME <u>PHILLIP BAUER</u>		14. MOTHER'S MAIDEN NAME <u>Marie Haesman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes 1st W War</u>		16. SOCIAL SECURITY NO. <u>269-09-8435H</u>	
17. INFORMANT (Wife) <u>Mrs. Gretchen Bauer</u>		Address <u>As Above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Acute Coronary thrombosis</u> <u>420.0</u> DUE TO (b) <u>Atherosclerotic hypertensive</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs.</u> <u>7 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1954</u> to <u>1961</u> , that (I) (we) last saw the deceased alive on <u>2/27</u> , 19 <u>61</u> , and that death occurred at <u>2 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Bernard J. Walsh</u>		22b. DATE SIGNED <u>2/27</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bernard J. Walsh</u>		22d. ADDRESS <u>1800 Eye St. N.W. - D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/1/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>ARLINGTON, VIRGINIA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WALTER E. PUMPHREY, INC.</u>		25a. REC'D BY REGISTRAR <u>MAR 6 '61</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1963

1963

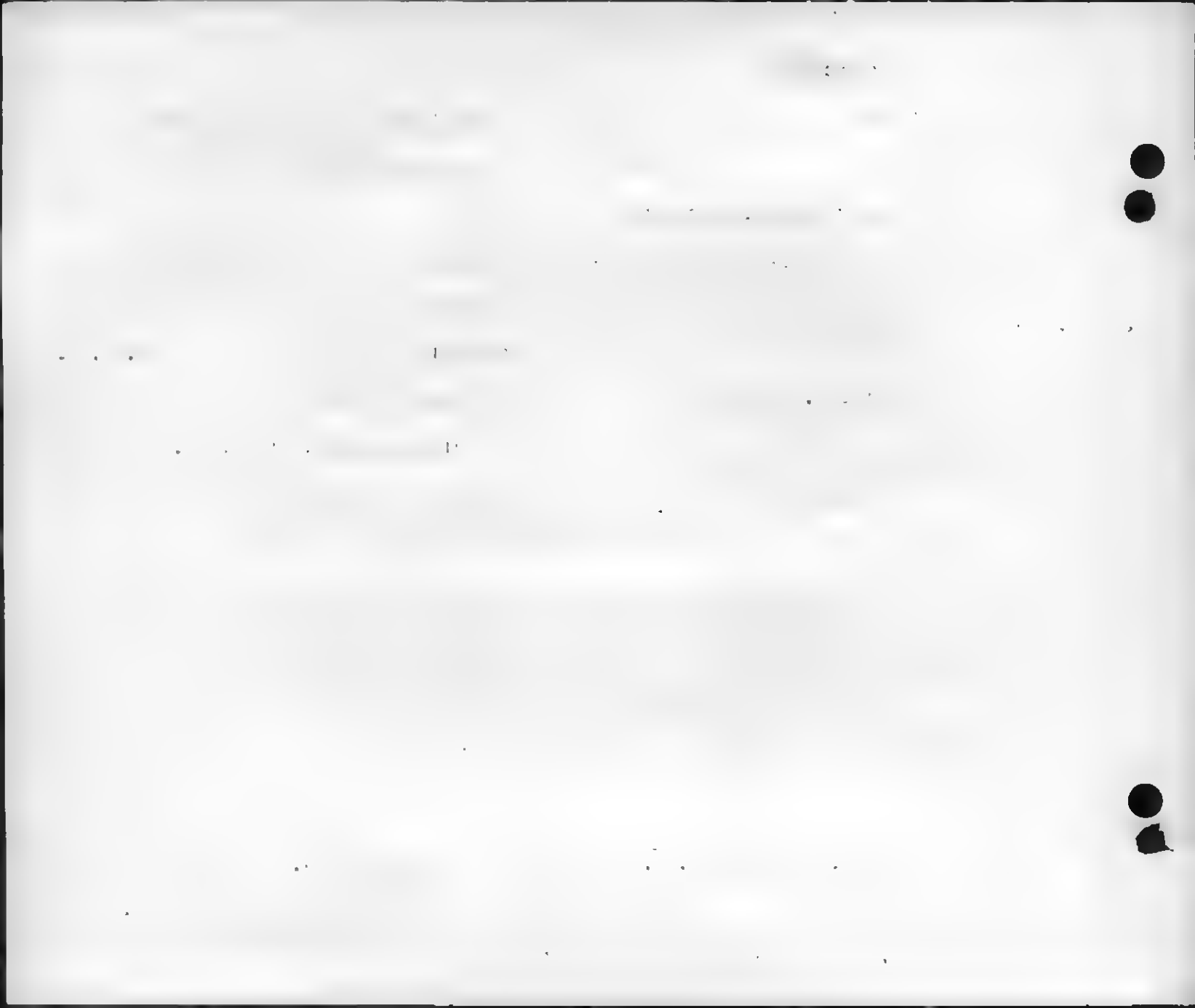


TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
 15M 9/59

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 2028
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
 020114

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 1 MONTH			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle SHELDON Last BECKER				4. DATE OF DEATH Month FEBRUARY Day 6 Year 19 61			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/15/98	
9. AGE (In years lost birthday) 62 yrs		F UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) WISCONSIN			
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME CHARLES H. BECKER				14. MOTHER'S MAIDEN NAME EMMA PREBBS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT HOSPITAL RECORDS, OLNEY, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphoma, retroperitoneal DUE TO with generalized metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 mo.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 1960 to Feb. 6, 1961 , that (I) last saw the deceased alive on Feb. 5, 1961 , and that death occurred at 3:54 P.M. from the causes and on the date stated above.							
22a. SIGNATURE A. F. Woodward 22c. PHYSICIAN'S NAME (Type) A. F. WOODWARD, M. D.				M. D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 2/6/61	
22d. ADDRESS ROCKVILLE, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-8-61		23c. NAME OF CEMETERY OR CREMATORY Forest Oak		23d. LOCATION (City, town, or county) (State) Gaithersburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner.				25a. REC'D BY REGISTRAR Gaithersburg, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed in 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2029

Reg. Dist. No. 02000

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN TB <u>years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		d. STREET ADDRESS <u>7112 Mayfield Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Windsor Green & Ho</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Edward</u> Last <u>Bill</u>				4. DATE OF DEATH Month <u>2</u> Day <u>11</u> Year <u>1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-24-1879</u>	
9. AGE (In years last birthday) <u>81 1/2</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>17</u>		IF UNDER 24 HRS Hours <u>11</u> Min. <u>17</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>laborer</u>		11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Not available</u>				14. MOTHER'S MAIDEN NAME <u>Not available</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>7-20</u>		17. INFORMANT <u>James Edward Bill (same as #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Hour <u>19</u> a. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				22b. DATE THEREOF <u>Feb 14, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Edgar Grove Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Win Bern North Carolina</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Watson</u>				ADDRESS <u>254 Carroll St. N.W. N.C.</u>		24a. REC'D BY REGISTRAR <u>FEB 14 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>							

DATE SIGNED

2-11-61



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

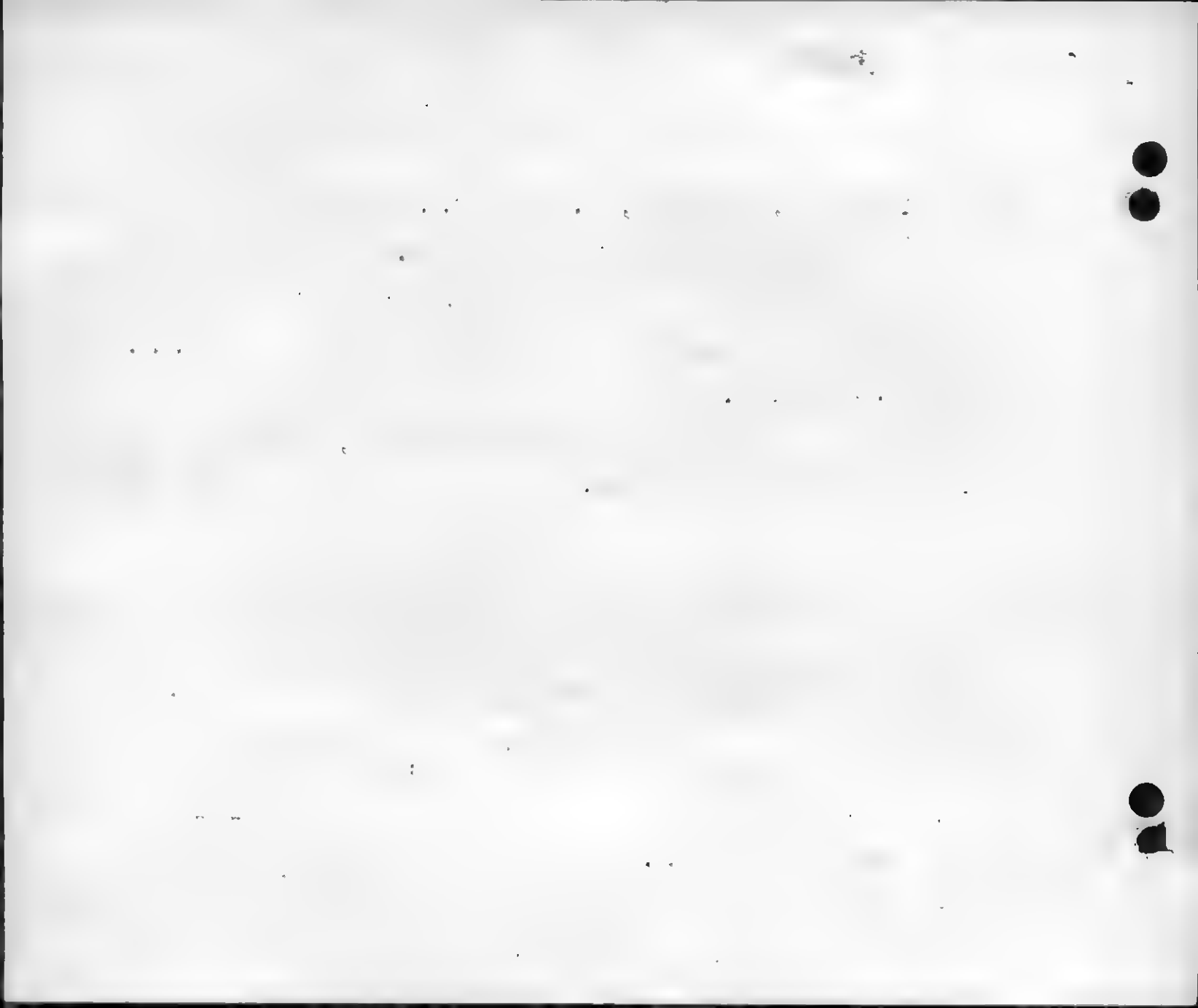
VR A15 (4)
ISM 9/59

2030

STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02006

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Florida b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 69 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Miami		d. STREET ADDRESS 5801 S.W. 34th Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Wit Whitfield Last Bennett Jr.		4. DATE OF DEATH Month February Day 12 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1913
9. AGE (In years last b rthday) 47 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motel Manager		10b. KIND OF BUSINESS OR INDUSTRY Motel	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert W. Bennett, Sr.		14. MOTHER'S MAIDEN NAME Elizabeth Biener	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO Unascertainable	
17. INFORMANT The Medical Records		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Choriocarcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 year		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from December 5, 1960 to February 12, 1961 , that (I) (we) last saw the deceased alive on February 12, 1961 and that death occurred at 6:35 PM , from the causes and on the date stated above			
22a. SIGNATURE Wendell F. Rosse 6 M.D.		22b. ADDRESS The Clinical Center National Institutes of Health Bethesda 14, Maryland	
22c. PHYSICIAN'S NAME (Type) Wendell Rosse M.D.		22d. ADDRESS The Clinical Center National Institutes of Health Bethesda 14, Maryland	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial-Trans		23b. DATE THEREOF 2/13/61	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Miami Florida	
24. FUNERAL DIRECTOR'S SIGNATURE Robert Q. Pumphrey		25a. REC'D BY REGISTRAR Bethesda, Maryland	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline		25c. DATE FEB 15 '61	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 3443. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

2031 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02007

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY N 1b <u>8 min</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash San & Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if last before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>2825 Briggs Chase</u>	
3. NAME OF DECEASED (Type or print) <u>Julian Ann Berry Sr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF DEATH <u>2-18-61</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>	
13. FATHER'S NAME <u>Samuel William Berry</u>		14. MOTHER'S MAIDEN NAME <u>Pallie Hughes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Julian A. Berry Jr - 54 ml</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ASPHYXIA DUE TO MASSIVE PULMONARY EDEMA</u> <u>825X</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. } DUE TO <u>MYOCARDIAL INFARCTION, OLD.</u> (c) <u>AUTOMOBILE ACCIDENT</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>825X</u> <u>SOODEN</u> <u>YEARS.</u> <u>IMMEDIATE</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>2-18-61</u> Hour <u>10:45</u> a.m.		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not while at work</u> <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>highway</u>		20f. (City or town) <u>Silver Spring</u> (County) <u>Montgomery</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Injury <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Bryschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Bryschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>Feb 21-1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mark's Episcopal</u>		22d. LOCATION (City, town, or county) <u>Frederick - Montgo</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR <u>Frederick</u>		24a. REC'D BY REGISTRAR <u>FEB 23 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hanna</u>	

1. 19.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2032

CERTIFICATE OF DEATH

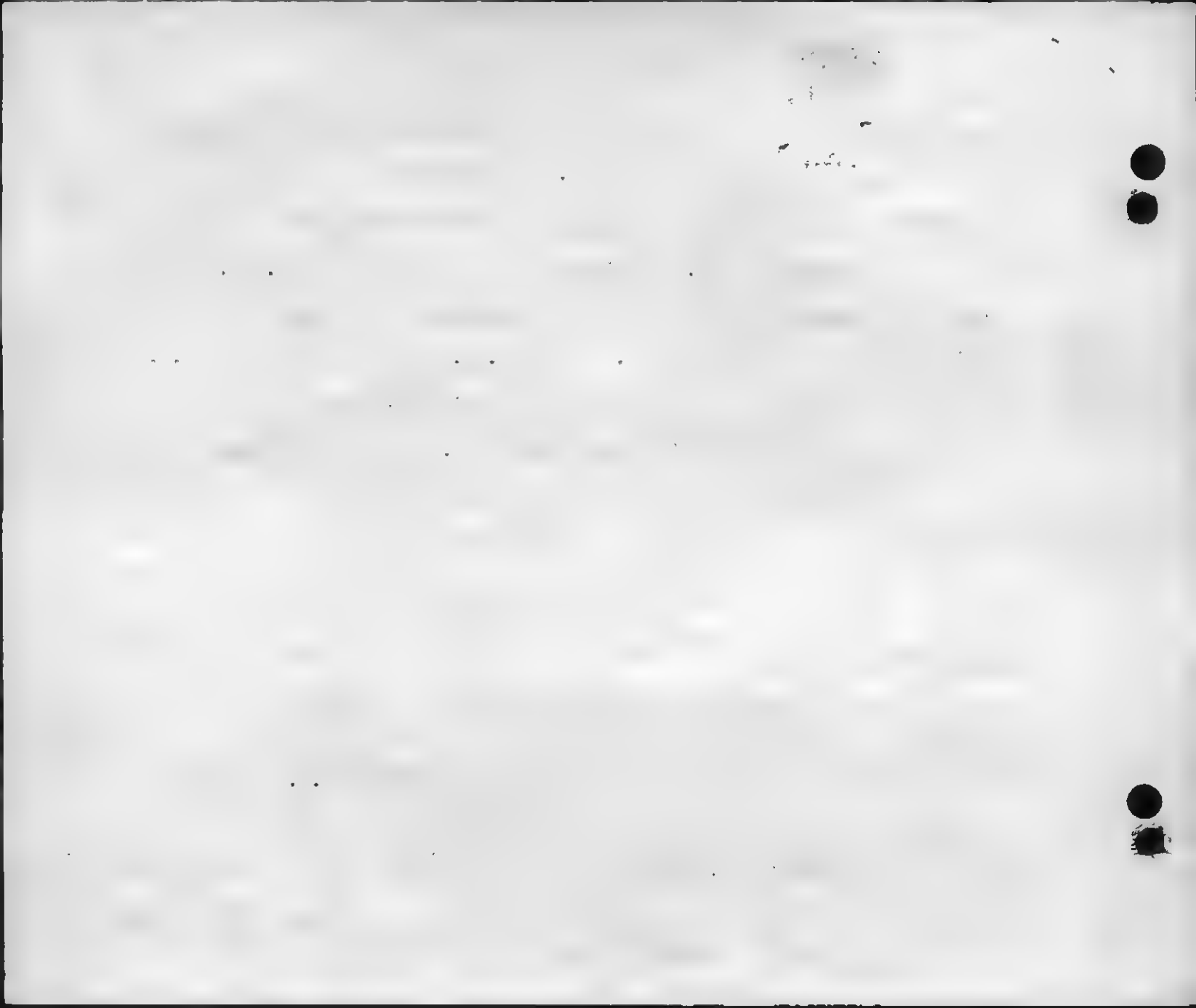
02068

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>1 1/2 da.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>5415 Lambeth Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Alfred K. Bisset</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 19, 1961</u> 9. AGE (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Power Co.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>D. C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Peter Bisset</u> 14. MOTHER'S MAIDEN NAME <u>Marie Anderson</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) 16. SOCIAL SECURITY NO. <u>577-05-0286</u> 17. INFORMANT <u>Helen S. Bisset-Wife-same 2d</u> Address <u> </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> (b) <u>Cerebral Thrombosis</u> (c) <u>Cerebral arteriosclerosis</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>36 hr.</u> <u>36 hr.</u> <u>Indefinite</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY: Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u> 20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>2/21/1961</u> to <u>2/21/1961</u> that (I) (we) last saw the deceased alive on <u>2/21/1961</u> and that death occurred at <u>7:20 P.M.</u> the causes and on the date stated above. 22a. SIGNATURE <u>Stephen N. Jones M.D.</u> 22b. DATE SIGNED <u>2/21/61</u> 22c. PHYSICIAN'S NAME (Type) <u>Stephen N. Jones</u> 22d. ADDRESS <u>Rockville Medical Center, Rockville</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2/22/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u> 23d. LOCATION (City, town or county) <u>Rockville, Maryland</u> (State) <u> </u>				24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Maryland</u> 25a. REC'D BY REGISTRAR <u>FEB 21 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death.



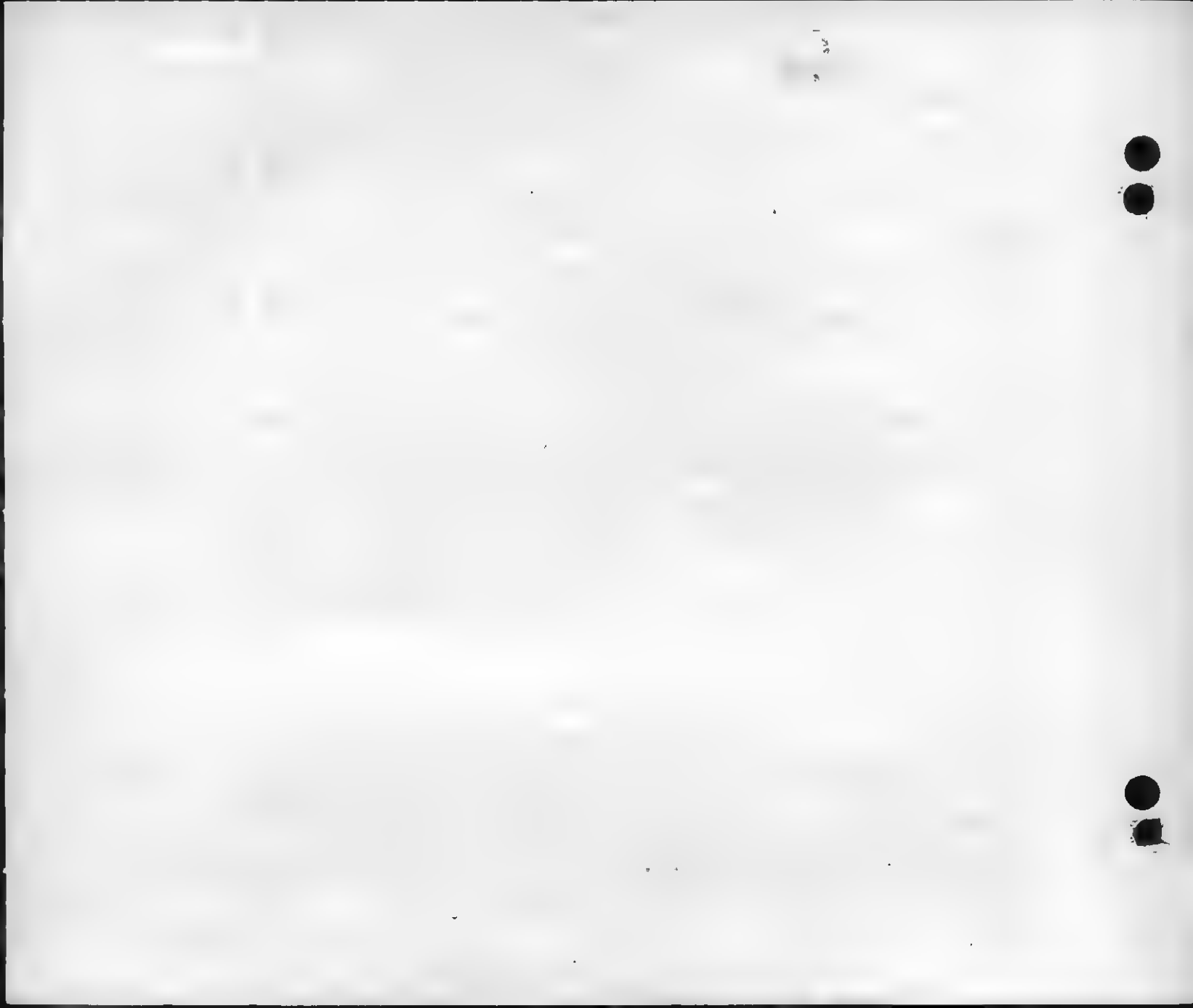
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2033

CERTIFICATE OF DEATH

Reg. Dist. No. 02009

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN TB <u>4 MO.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RALLS Nursing Home</u>				STREET ADDRESS <u>7611 TAKOMA AVE.</u>			
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Denton</u> Last <u>Bliss</u>				4. DATE OF DEATH Month <u>February</u> Day <u>6</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 31, 1871</u>	9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u> Hours <u>01</u> Min <u>00</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>Newburgh, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Emerson W. Bliss</u>				14. MOTHER'S MAIDEN NAME <u>Sarah P. Denton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>578-14-6228</u>		17. INFORMANT <u>Lillian L. Bliss</u> Address <u>7420 Maple Ave. Takoma Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>191X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>191X</u> DUE TO (c) <u>191X</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>00</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-1</u> , 19 <u>58</u> , to <u>2-6</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>2-5</u> , 19 <u>61</u> , and that death occurred at <u>1:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arnold McNitt</u> M.D.				ADDRESS (Street, city or town, state) <u>1835 Eye St., N.W., Washington, D.C.</u>			
PHYSICIAN'S NAME (Type) <u>Arnold McNitt M.D.</u>				DATE SIGNED <u>Feb 8 '61</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Interment</u>		22b. DATE THEREOF <u>Feb. 8, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Mausoleum</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George's County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Julius Tracton</u>				ADDRESS <u>254 Carroll, N.W.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	
24a. REC'D BY REGISTRAR <u>Feb 8 '61</u>				DATE <u>Feb 8 '61</u>			



Reg. Dist. No. 02010

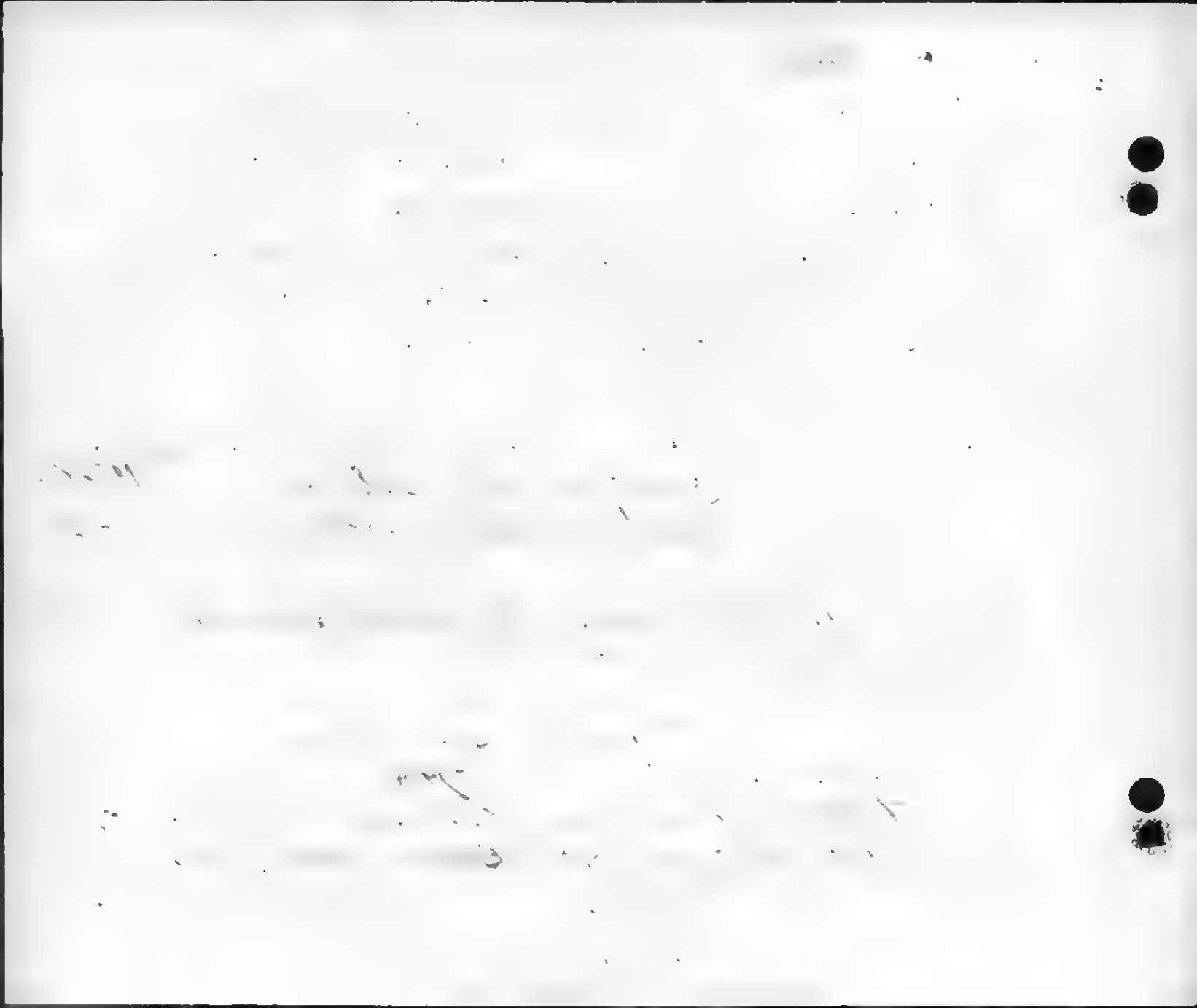
2034

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Kenwood Pk)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Kenwood Park)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5817 Midhill				d. STREET ADDRESS 5817 Midhill		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emory		First H.		Last BOGLEY		4. DATE OF DEATH Month February , Day 3 , Year 19 61	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 16, 1880	
9. AGE (In years last birthday) 80 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Attorney		11. BIRTHPLACE (State or foreign country) Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Attorney		11. BIRTHPLACE (State or foreign country) Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Attorney		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Bogley				14. MOTHER'S MAIDEN NAME Catherine Haney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Mrs. Jennie A. Bogley-wife-Same Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 332x IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2+yr DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis / Heart Disease 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour o m 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 15 July 46 , 19 46 , to 3 FEB , 19 61 , that I last saw the deceased alive on 3 FEB , 19 61 , and that death occurred at 249 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5522 WESTERN AVE DATE SIGNED 3 FEB ACTUAL SIGNATURE A. H. Richwine M.D. 5522 WESTERN AVE PHYSICIAN'S NAME (Type) A. H. RICHWINE CHEVY CHASE, MD. 1961							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/6/1961		22c. NAME OF CEMETERY OR CREMATORY Rockville		22d. LOCATION (City, town, or county) (State) Rockville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE FEB 8 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

HOSPITAL: [REDACTED] hospital or attending physician.
[REDACTED] may be returned to [REDACTED]. Page 4

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2035

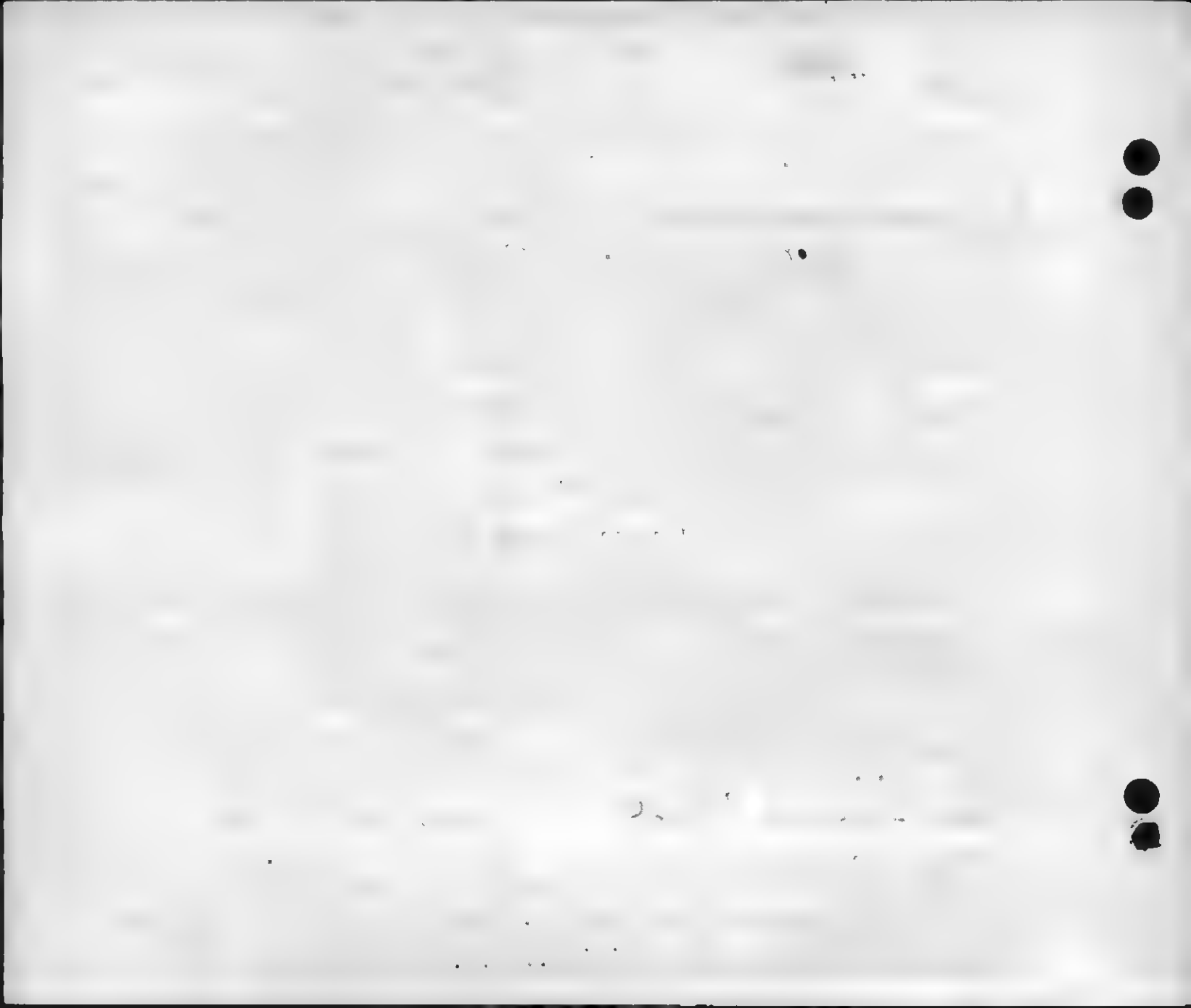
CERTIFICATE OF DEATH

Reg. Dist. No.

02011

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg, Rt. # 2		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) Pleasant View Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK	
f. STREET ADDRESS 6705 POPLAR AVE.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dolores Middle E. Last Bolden		4. DATE OF DEATH Month Feb Day 8 Year 1961	
5. SEX Female	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 29
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) DC		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Annamis Page		14. MOTHER'S MAIDEN NAME Harriet	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Nursing Home Records		Address Rt # 2 Gaithersburg, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) Senility			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 60 , to Feb 8 , 19 61 , that I last saw the deceased alive on Feb. 7 , 19 61 , and that death occurred at 5:16 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Luciano I. Leal		ADDRESS (Street, city or town, state) 108 N. Frederick Ave. DATE SIGNED	
PHYSICIAN'S NAME (Type) Luciano I. Leal.		Gaithersburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/11/61	
22c. NAME OF CEMETERY OR CREMATORY HARMONY MEM. PARK		22d. LOCATION (City, town, or county) (State) MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Robert J. McGuire		ADDRESS WASHINGTON ST., N.W.	
24a. REC'D BY REGISTRAR DATE FEB 10 '61		24b. REGISTRAR'S SIGNATURE C. H. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following are not applicable, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director, page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2036 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02012

Item 9 Film G282-3/1/61

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4801 North Lane

2. NAME OF DECEASED (Type or print) Eva Louise Bostock
3. SEX Female 4. DATE OF DEATH Feb 25 1961
5. COLOR OR RACE White 6. MARRIED ☒ NEVER MARRIED ☐ 7. DATE OF BIRTH 3/19/79
8. AGE (In years last birthday) 88 9. IF UNDER 1 YEAR: Months 11 Days 6 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY -----
11. BIRTHPLACE (State or foreign country) Pennsylvania 12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME (Unknown) Savidge 14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. 339-07-0514A 17. INFORMANT Donald E. Bostock, son-
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial Infarction
Conditions, if any, which gave rise to immediate cause (b) Hemorrhage into Atherosclerotic plaque
(a), stating the underlying cause last. (c) Coronary atherosclerosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).
20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 3/1/61 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
ACTUAL SIGNATURE Frank J. Bostock M.D. DATE SIGNED 2-26-61
EXAMINER'S NAME (Type) FRANK J. BOSTOCK Address (Street, city, town, or county)
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 3/1/61 22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery 22d. LOCATION (City, town, or country) (State) Rockville, Maryland
23. FUNERAL DIRECTOR Robert A. Pumphrey Bethesda, Maryland 24a. REC'D BY REGISTRAR FEB 28 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Knead

MEDICAL CERTIFICATION

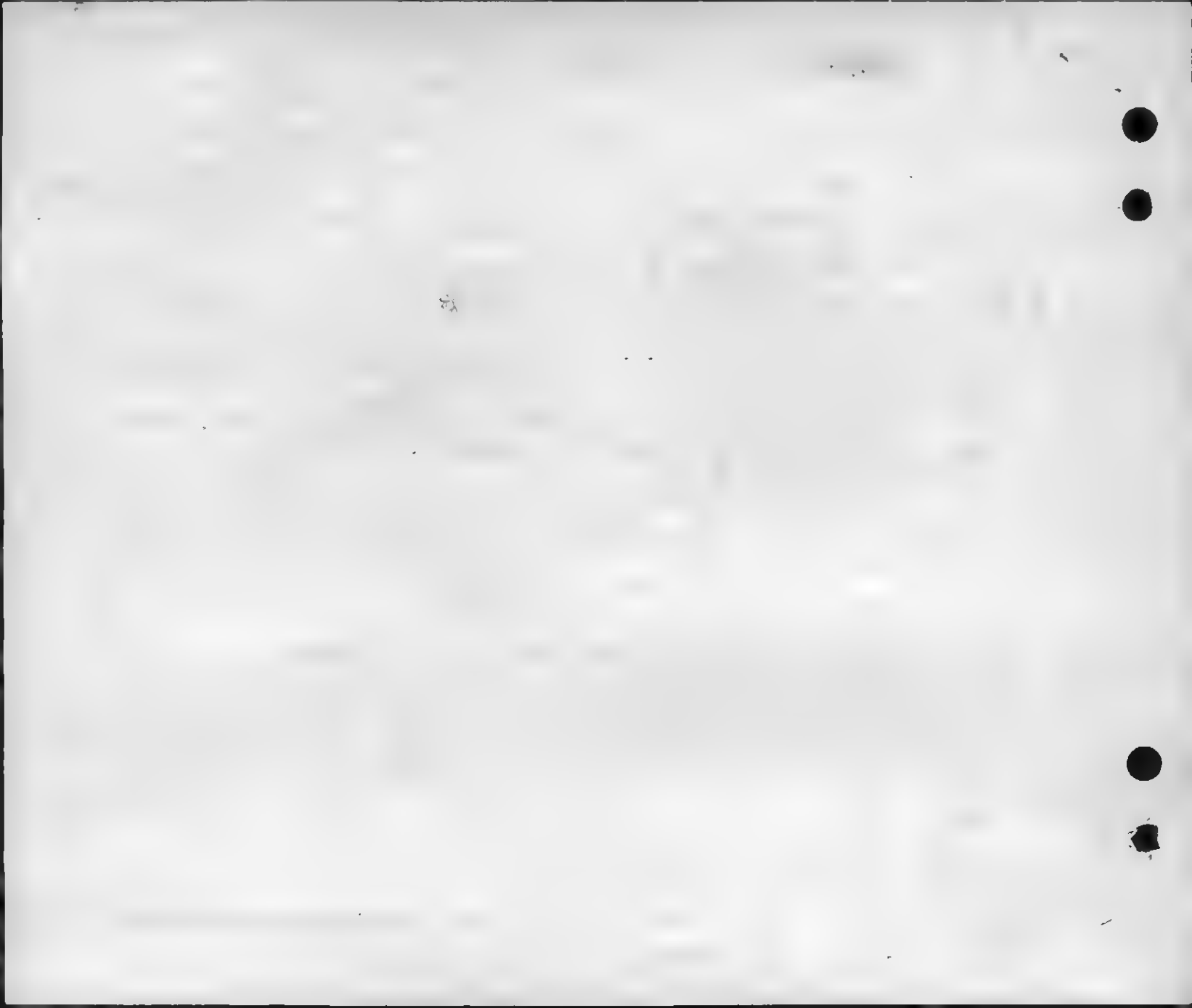
INTERVAL BETWEEN ONSET AND DEATH

6 hrs

6 hrs

Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2037

02013

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>15 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if inst'l on residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10008 Sutherland Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harold Leopold Bradford</u> First Middle Last		4. DATE OF DEATH <u>February 4 1961</u> Last Month Day Year	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc.</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>8-21-84</u>		9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done 1/2 year of working life, even if retired) <u>Ma. Nat'l Park & Park & Planning Comm. Planning Commission</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Ma. Nat'l Park & Park & Planning Comm. Planning Commission</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John L. Bradford</u>		14. MOTHER'S MAIDEN NAME <u>Emma Wert</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>578-07-2930</u> 17. INFORMANT <u>Patient - Mr. Harold Bradford</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASPIRATION OF GASTRIC CONTENT KRN.</u> <u>540.0</u> DUE TO <u>CHRONIC THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>ULCERS, GASTRIC AND DUODENAL, PEPTIC (5) KRN.</u> (b) <u>GENERALIZED ARTERIO-SCLEROSIS</u> (c) <u>PULMONARY ATELECTASIS AND RESOLVING PNEUMONIA KRN.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fx L HIP</u>			
19. INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u> <u>WEEKS KRN.</u> <u>SEVERAL YEARS KRN.</u> <u>DAYS KRN.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>FELL AT WORK 1/18/61</u> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year <u>1/18 19 61</u> Hour <u>8</u> p.m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>PARK & PLANNING COMM</u>		20f. (City or town) <u>SS</u> (County) <u>MONTGOMERY</u> (State) <u>MD</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1/18/61</u> , 19 <u>61</u> , to <u>2/4/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>2/3/61</u> , 19 <u>61</u> , and that death occurred at <u>3:25</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>George L. Rivatmo</u>		22b. DATE SIGNED <u>2/3/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>GEORGE L. RIVATMO</u>		22d. ADDRESS <u>1062 C Georgia Ave., S.S., MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/8/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>COLESVILLE CEMETERY</u>		23d. LOCATION (City, town or county) <u>MONTGOMERY COUNTY, MARYLAND</u> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond W. Ziska</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 10 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

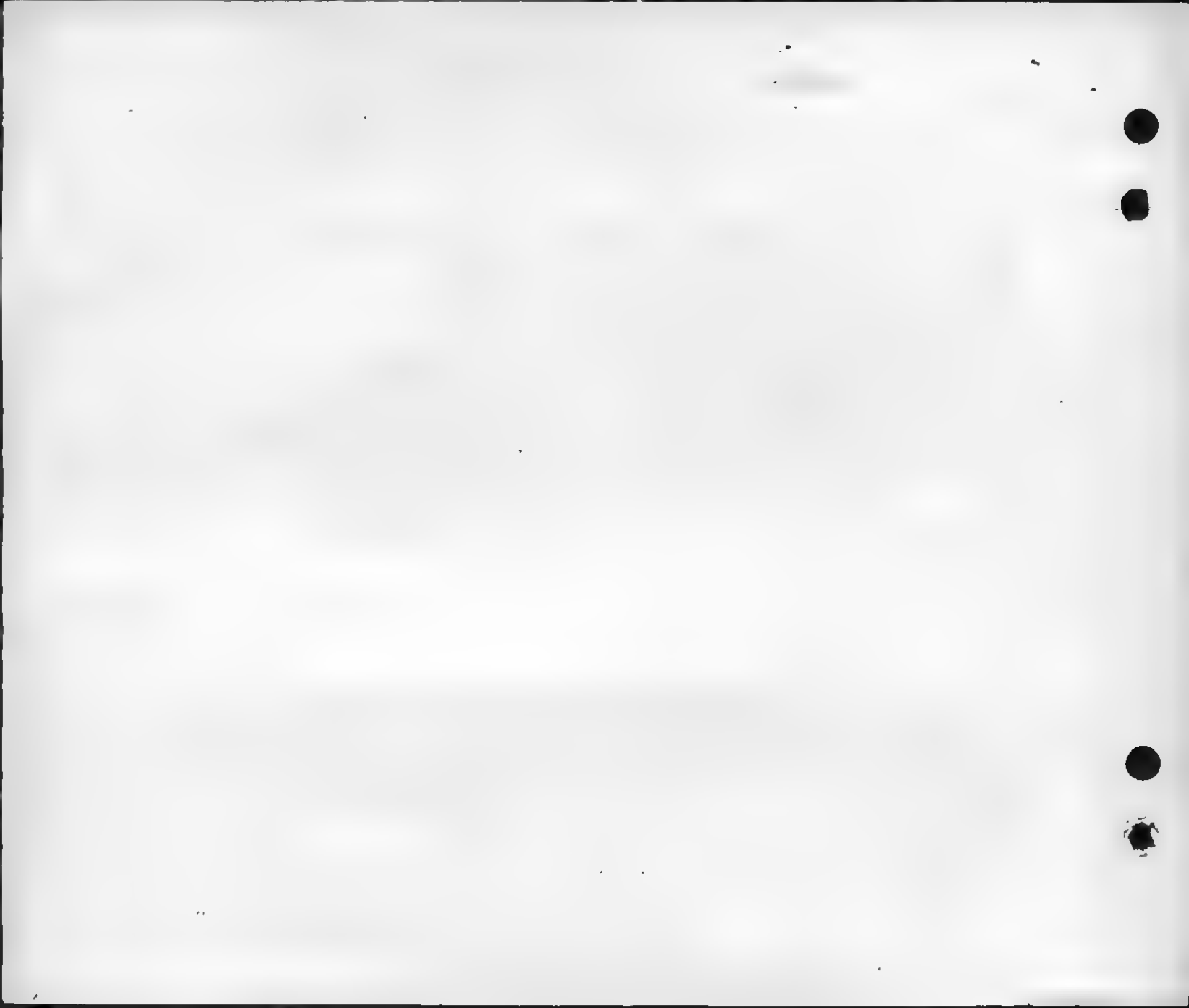
CERTIFICATE OF DEATH

Reg. Dist. No.

02014

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b Bethesda		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 4869 Battery Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Florence Bailey Bradley First Middle Last		4. DATE OF DEATH Feb. 14 1961 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/10/83
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 3 Days 4 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles E. Bailey		14. MOTHER'S MAIDEN NAME Ida Jewell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Donald Deane, daughter-same 2d Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1, 1954 to Feb. 14, 1961 that I last saw the deceased alive on 2-13-61 and that death occurred at 3:30 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1719 Remondy Rd. Silver Spring Md. DATE SIGNED 2-24-61			
ACTUAL SIGNATURE John S. Rogers, M.D.		PHYSICIAN'S NAME (Type) John S. Rogers, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/16/61	
22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR FEB 17 1961 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

18 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be related by the attending physician or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

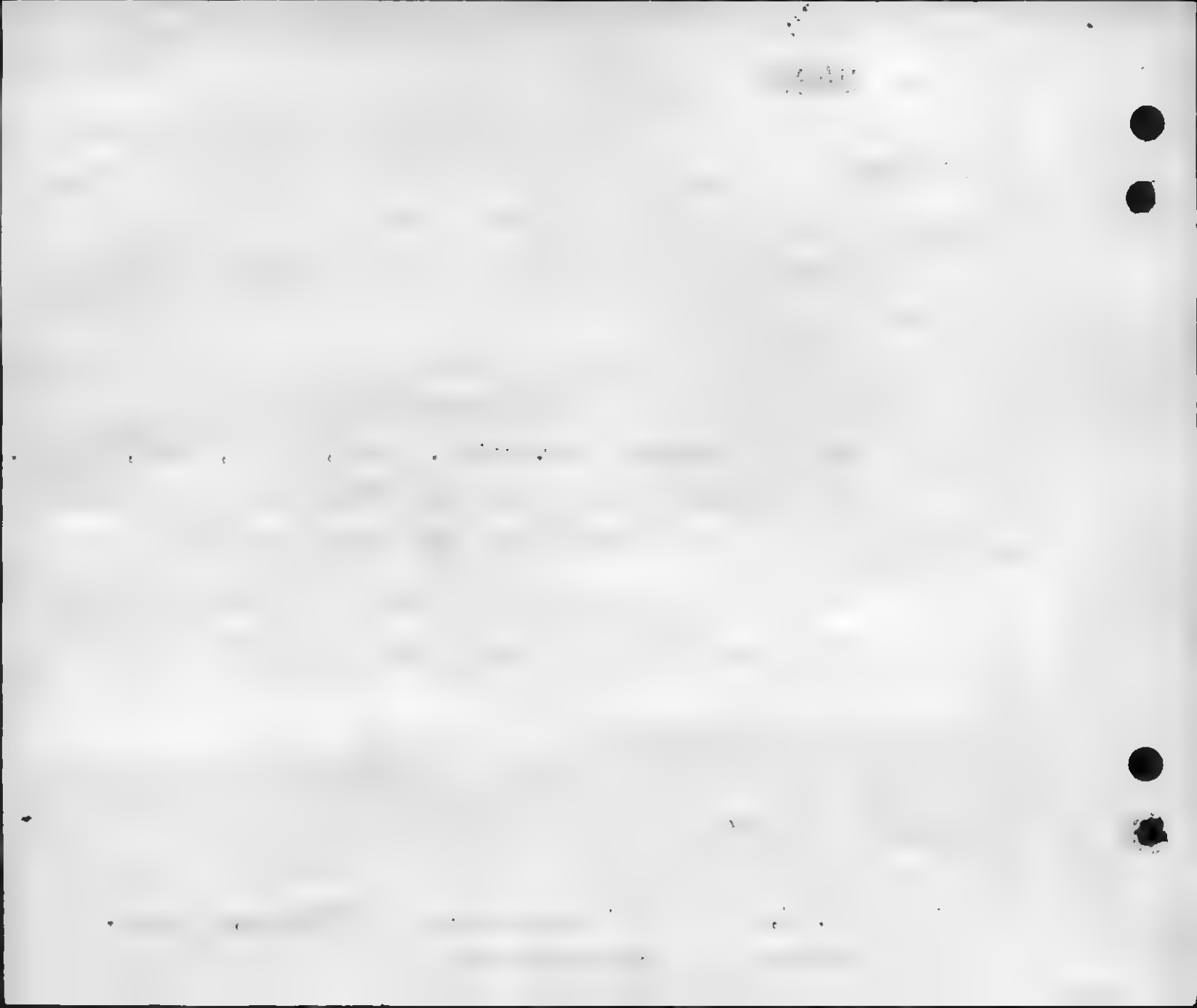
CERTIFICATE OF DEATH

02010

2039

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lanham</u> d. STREET ADDRESS <u>9607 Telegraph Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Josephine Ruth BRENNAN</u> First Middle Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 14 - 1919</u> 9. AGE (In years last birthday) <u>41</u> yrs. If UNDER 1 YEAR: Months <u>22</u> Days <u>19</u> Hours <u>61</u> Min. 10. KIND OF BUSINESS OR INDUSTRY <u>At home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>America U.S.</u>	
13. FATHER'S NAME <u>David Baumbach</u> 14. MOTHER'S MAIDEN NAME <u>Josephine Bauerline</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>No</u> (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Mr. David E. Brennan, Road, Lanham, Maryland.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma to the liver</u> (b) <u>Primary carcinoma of the cervix (operated)</u> (c) <u>6 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>None</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year <u>Jan. 21, 1961</u> Hour a.m. <u>19</u> p.m. <u>12</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>918 Univ. Bldg. E., Silver Spring, Md.</u> 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 21, 1961</u> to <u>Feb. 22, 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb. 22, 1961</u> , and that death occurred at <u>12:5 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Eino Magi</u> 22c. PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>		22b. DATE SIGNED <u>2/22/61</u> 22d. ADDRESS <u>918 Univ. Bldg. E., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Feb. 24, 1961</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u> 23d. LOCATION (City, town or county) <u>Bladensburg, Maryland</u> 25a. REC'D BY REG. STR. <u>RIVERDALE, MD</u> 25b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



①

2040

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WASH.		b. COUNTY D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASH D.C. 17	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Reesor Hospital		d. STREET ADDRESS 5084 Lowell St. N.W. W		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emma First XXXXX Middle X Lena Last Bricker		4. DATE OF DEATH Month Feb. Day 11. Year 1961			
5. SEX F	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-21-1897	9. AGE (In years last birthday) yrs 83	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wash, D.C.	
12. CITIZEN OF WHAT COUNTRY? Am United St.		13. FATHER'S NAME William Braumerschewer		14. MOTHER'S MAIDEN NAME Harriet Long	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Edwin D. Bricker - XXXXXX Husband - same d2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized arteriosclerosis with cardio vascular renal disease DUE TO (b) with cardio vascular renal disease DUE TO (c) disease		INTERVAL BETWEEN ONSET AND DEATH 3-4 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 610P	
20f. (City or town) Washington		(County) D.C.		(State) D.C.	
21. I certify that (I) (this hospital) attended the deceased from Dec 1955 to present , that (I) (we) last saw the deceased alive on 2-11-1961 , and that death occurred at 6:00 P.M. from the causes and on the date stated above					
22a. SIGNATURE C P Ryland		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-11-61	
22c. PHYSICIAN'S NAME (Type) C P RYLAND		22d. ADDRESS 4400-49th St N W Washington DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/15/61		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.	
23d. LOCATION (City, town, or county) Arlington, Virginia		(State) DC			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE FEB 15 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Harris					



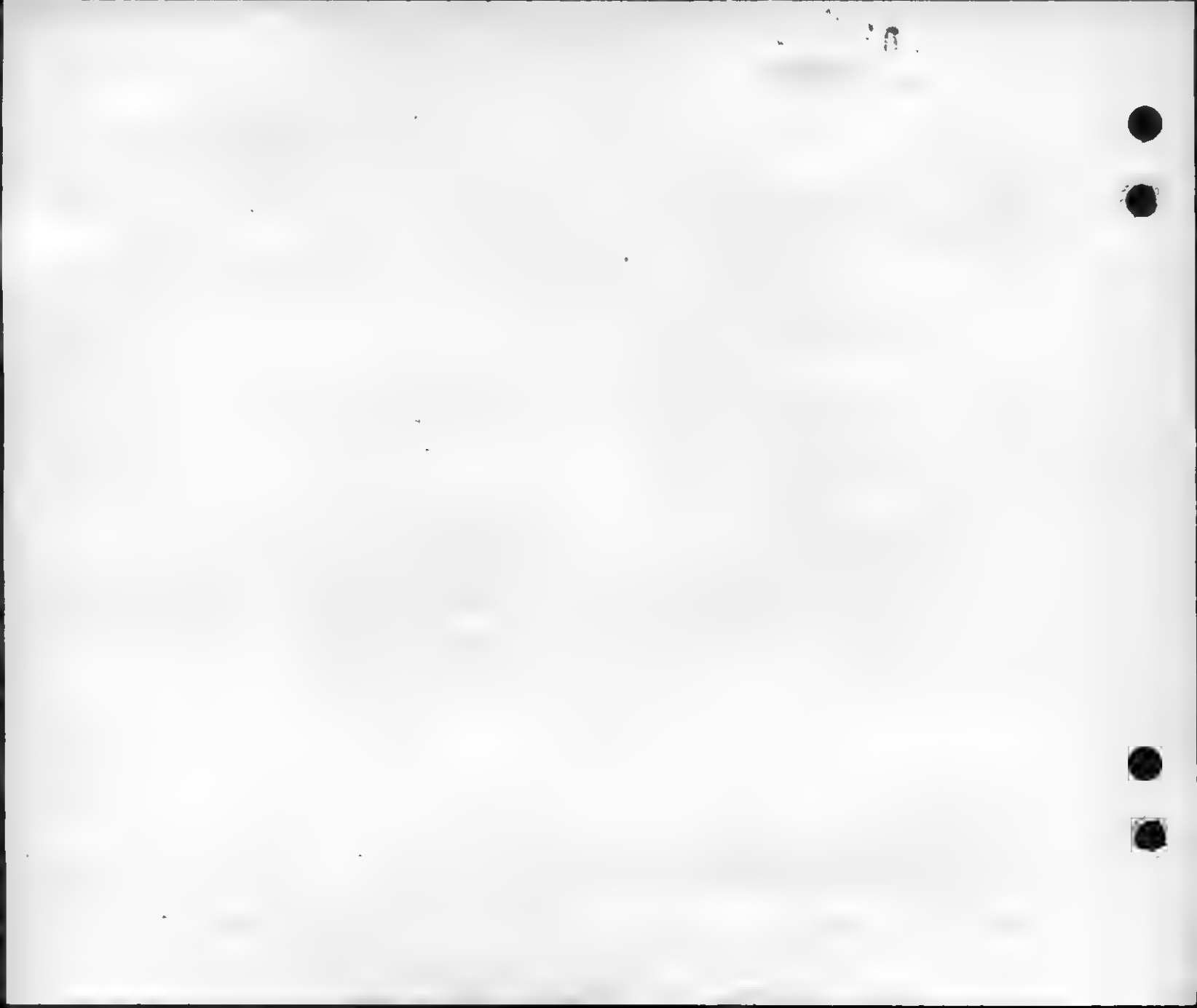
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02018

2041

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 32 hrs.		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admision) a. STATE D.C.		b. COUNTY Washington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47 X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. STREET ADDRESS 3333 Runnymede Pl., N.W.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
NAME OF DECEASED (Type or print) First Mary		Middle D.		Last Brown		4. DATE OF DEATH Month 2		Day 27		Year 1961	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 6, 1877		9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR Months 2	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Thomas Veale				14. MOTHER'S MAIDEN NAME Mary DeBell							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT (Daughter) Elizabeth D. Barnes		Address as above					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial anoxemia & respiratory failure due to 199.2 DUE TO Conditions in any which gave rise to immediate cause (a), stating the underlying cause last. (b) Anemia, due malabsorption due to DUE TO (c) Terminal carcinoma										INTERVAL BETWEEN ONSET AND DEATH 7 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) acute coronary heart failure Hypertension											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Jan 25 to Feb 27 , 1961, that (I) last saw the deceased alive on Feb 26 , 1961, and that death occurred at 12 AM, from the causes and on the date stated above											
22a. SIGNATURE Margaret E. Callan		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-27-61			
22c. PHYSICIAN'S NAME (Type) Margaret E. Callan		22d. ADDRESS 4700 Bradley Blvd. Chevy Chase, Md.									
23a. BURIAL, CREMATATION OR REMOVAL (Specify) burial		23b. DATE THEREOF 2/27/61		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town, or county) Washington, D.C.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE 2501-14th St. N.W. Wash, D.C.		25a. REC'D BY REGISTRAR MAR 1 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline							

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The attending physician or attending physician may be requested by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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2042
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
02019

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>5 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oakhaven Convalescent Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hamilton</u> Middle <u>Bryden</u> Last <u>Bryden</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>12</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 6 1878</u>
9. AGE (In years last birthday) <u>82</u> yrs		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sestland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Hamilton Bryden</u>		14. MOTHER'S MAIDEN NAME <u>Jane Hall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs Edward German</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Angiogram of the heart</u> <u>334 X</u> DUE TO <u>inter-clarin</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u> </u> DUE TO <u> </u> (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21 I certify that (I) (this hospital) attended the deceased from <u>12/6</u> 19 <u>60</u> to <u>2/12/</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>2/8/</u> 19 <u>61</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above			
22a. SIGNATURE <u> </u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>W. W. Chambers</u>		22d. ADDRESS <u>Washington Sanitarium, Takoma Park, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-16-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u>		23d. LOCATION (City, town, or county) (State) <u>Bladensburg, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co Riverdale, Md</u>		25a. RECEIVED BY REGISTRAR DATE <u>Feb 14 '61</u>	
25b. REGISTRAR'S SIGNATURE <u> </u>		25c. REGISTRAR'S SIGNATURE <u> </u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2043

CERTIFICATE OF DEATH

02020

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Daytona Beach	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		d. STREET ADDRESS 3920 Oriole Avenue	

3. NAME OF DECEASED (Type or print) First Middle Last Stella Annice Buchs		4. DATE OF DEATH Month Day Year February 14, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1907
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hostess		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	

13. FATHER'S NAME Leonard Hudson		14. MOTHER'S MAIDEN NAME Matilda Jane King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Not available	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrhythmia and Arrest DUE TO (b) Diffuse non-specific metabolic abnormalities DUE TO (c) extensive carcinoma of palate		INTERVAL BETWEEN ONSET AND DEATH 15 min. weeks several months
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from **January 27, 1961**, to **February 14, 1961**, that (I) (we) last saw the deceased alive on **Feb. 14, 1961**, and that death occurred at **2:45 a.m.**, from the causes and on the date stated above.

22a. SIGNATURE David J. Crawford MD	22b. DATE 2/15/61
22c. PHYSICIAN'S NAME (Type) DAVID T. CRAWFORD, M.D.	22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/17/61	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d. LOCATION (City, town, or county) (State) Prince Georges County, Md.
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines company-		25a. REC'D BY REGISTRAR 2901 14th St., N.W. Washington 9, D.C. FEB 16 '61	25b. REGISTRAR'S SIGNATURE Caroline E. Kline

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

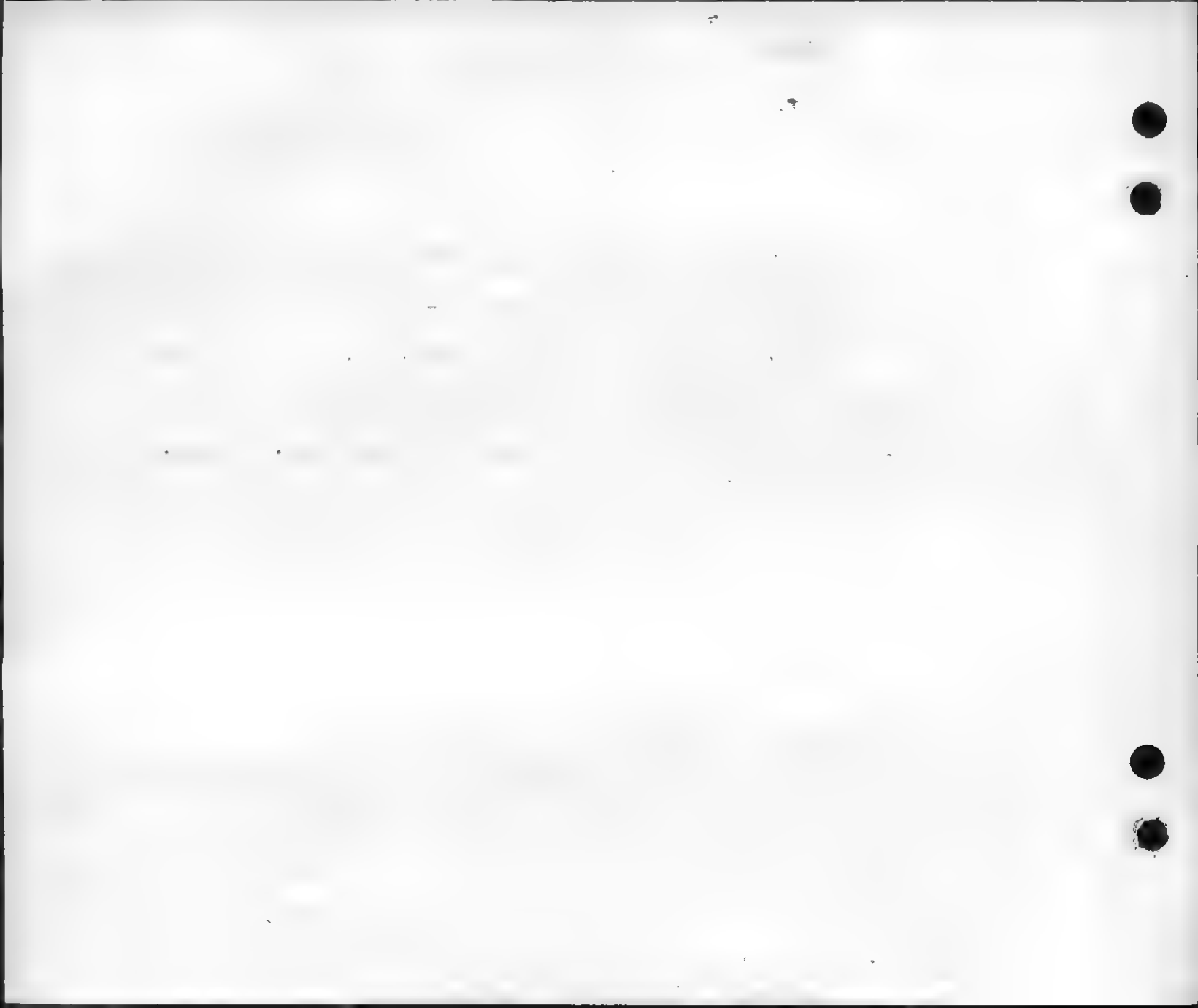
100



CERTIFICATE OF DEATH

Reg. Dist. No. 2021

VS A15 (4)
15M 9/58



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

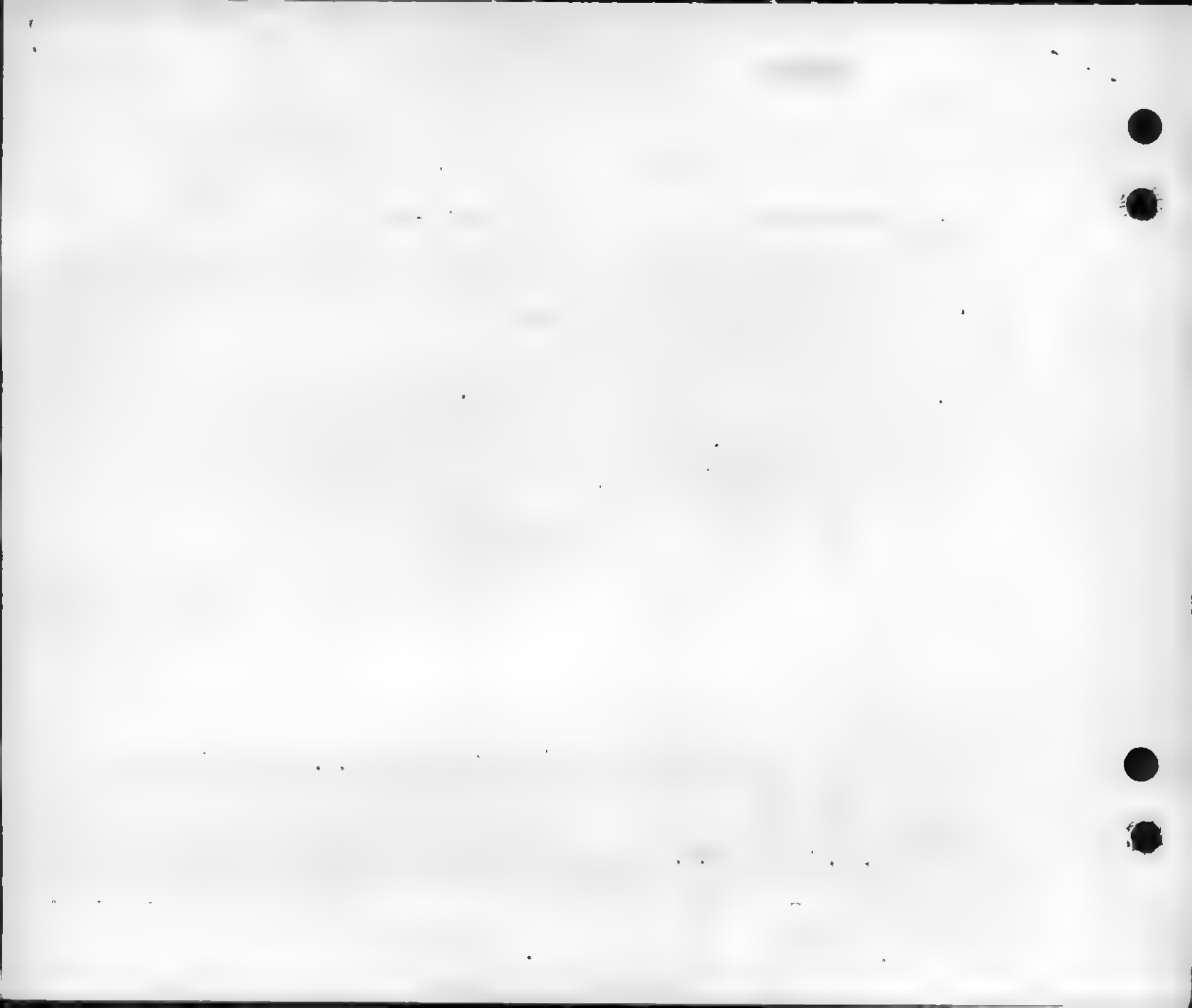
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2045

02022

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 4 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Pennsylvania b. COUNTY Allegheny c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsburgh 17 d. STREET ADDRESS 5543 Beeler Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Marian Myrtle Burgess				4. DATE OF DEATH Month Day Year February 2, 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 3, 1918	
9. AGE (In years last birthday) 42 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Fleming Shaw				14. MOTHER'S MAIDEN NAME Myrtle Mitts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Not Available		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive intrathoracic & gastrointestinal hemorrhage INTERVAL BETWEEN ONSET AND DEATH Hours DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Bilateral total atelectasis Minutes DUE TO (c) Aortic and Mitral stenosis Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 29, 19 61 to February 2, 1961 , that (I) (we) last saw the deceased alive on February 2, 1961 , and that death occurred at 2:25 a.m. , from the causes and on the date stated above.							
22a. SIGNATURE A. G. Morrow				22b. DATE SIGNED 2/2/61		22c. PHYSICIAN'S NAME (Type) A. G. Morrow, M.D.	
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland							
23a. BURIAL CREMATION, REMOVAL Burial-transit 2-2-61		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) Allegheny County, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY ADDRESS Bethesda, Md.				25a. REC'D BY REGISTRAR FEB 6 '61		25b. REGISTRAR'S SIGNATURE G. S. K.	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

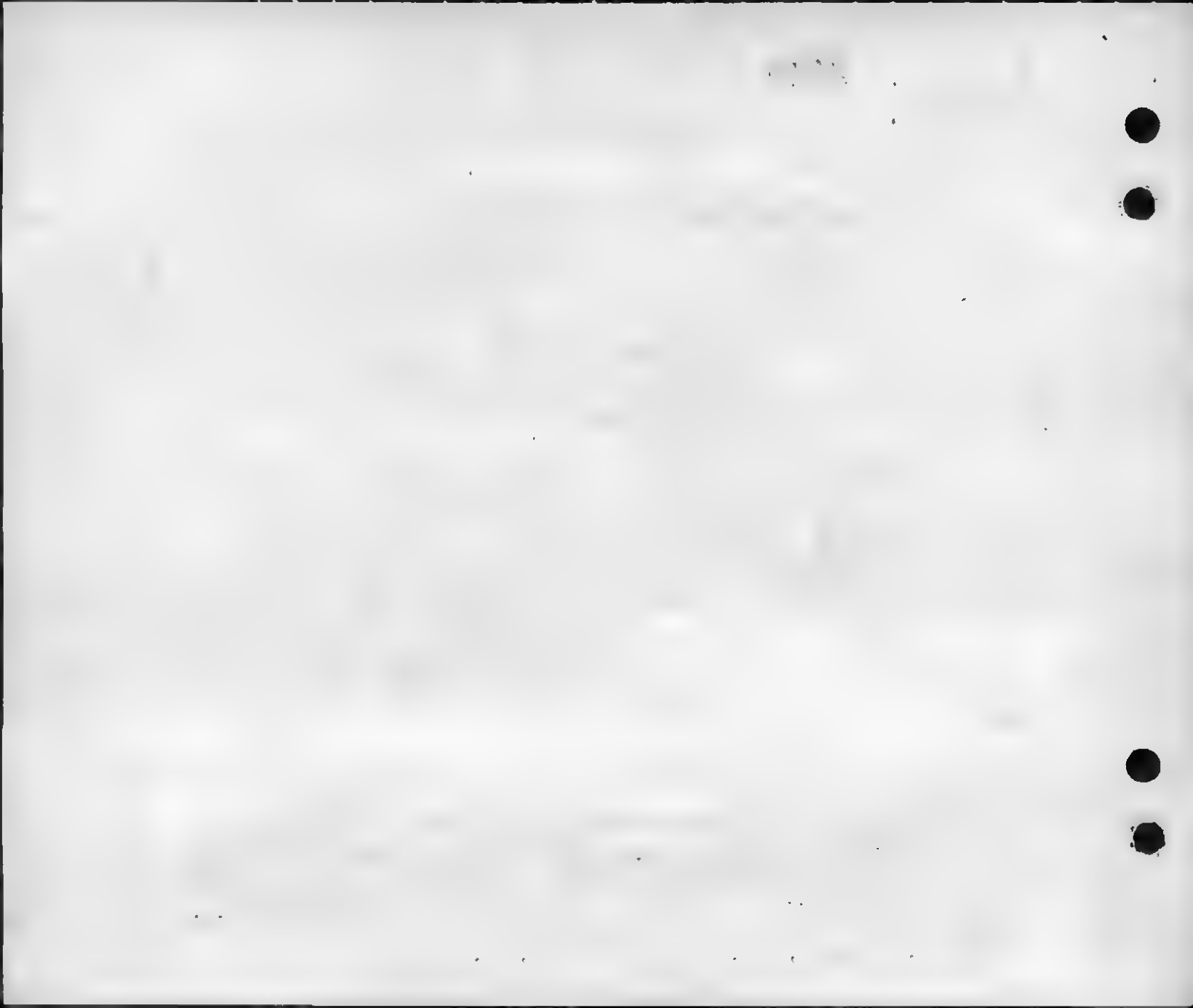
CERTIFICATE OF DEATH

2046

02023

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN (b) <u>WASHINGTON SANITARIUM + HOSPITAL</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4705 OLIVER STREET</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVERDALE</u> d. STREET ADDRESS <u>4705 OLIVER STREET</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LENA LOUISE BUSHBY</u>		4. DATE OF DEATH Month Day Year <u>FEB 14 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>1-15-78</u>		9. AGE (In years last birthday) <u>83 yrs.</u> IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of work no life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>			
11. BIRTHPLACE (County & State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>			
13. FATHER'S NAME <u>CHARLES HARTMAN</u>		14. MOTHER'S MAIDEN NAME <u>EMMA UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>HOSPITAL RECORD</u>		18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> (b) <u>Hypertension</u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>One day</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u> </u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>2/4/61 fall released by Broschart - Gruber</u>		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. City or town <u> </u>		20g. (County) <u> </u>			
20h. (State) <u> </u>		21. I certify that (I) (this hospital) attended the deceased from. <u>2/13/1961</u> to <u>2/14/1961</u> , that (I) (we) last saw the deceased alive on <u>2-13-1961</u> , and that death occurred <u>2:35 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert A. Hare M.D.</u>		22b. DATE SIGNED <u>2/14/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare M.D.</u>		22d. ADDRESS <u>7600 Carroll Ave., T.P. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/16/61</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>WASHINGTON, D.C.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Baska</u>		25a. REC'D BY REGISTRAR <u> </u>			
25b. REGISTRAR'S SIGNATURE <u> </u>		DATE <u>FEB 20 '61</u>			

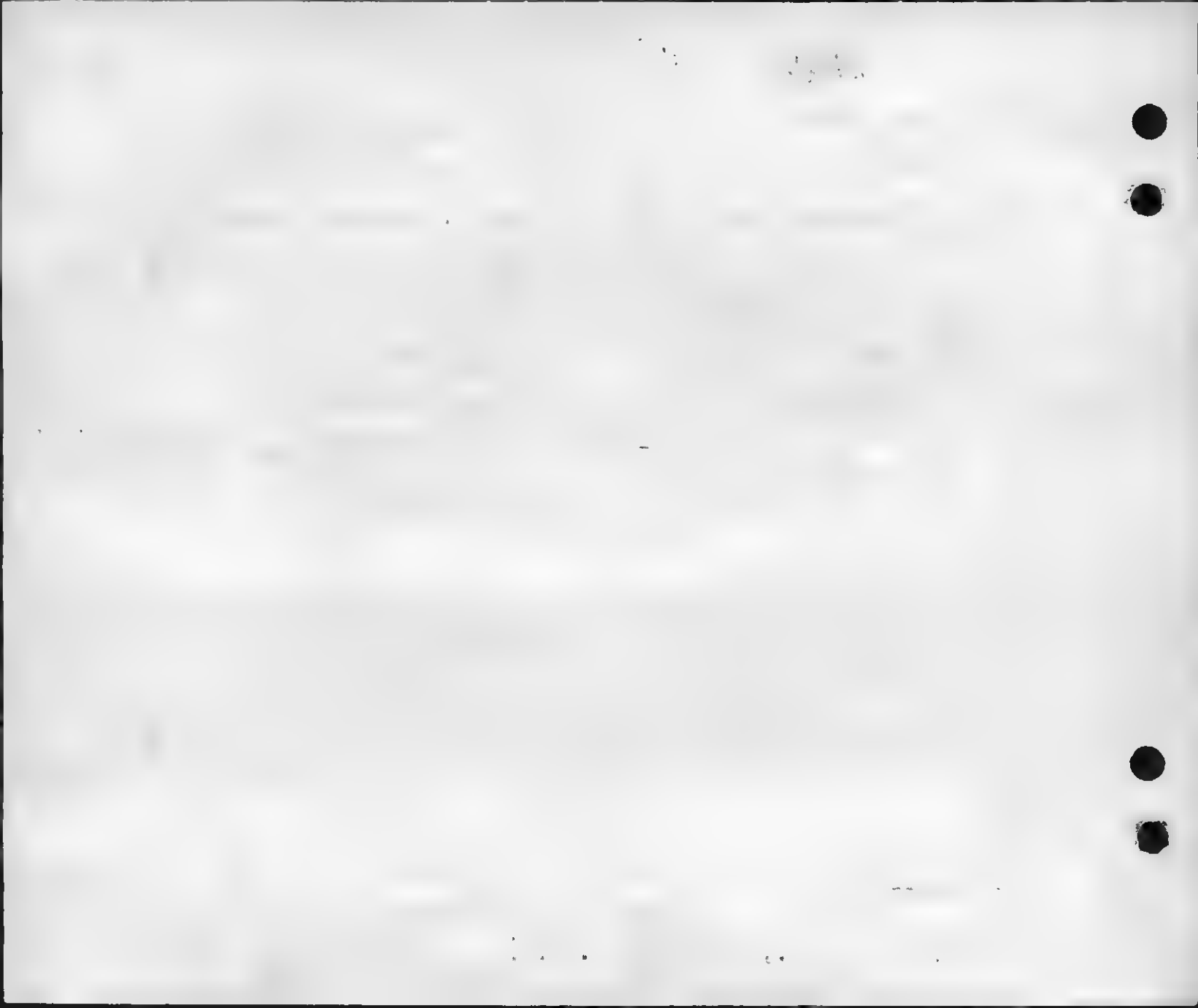
TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Pages may be signed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2047 CERTIFICATE OF DEATH											
120224											
1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN IL MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) OAK HAVEN CONVALESCENT HOME				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Illinois b. COUNTY Peoria c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Peoria d. STREET ADDRESS 500 N. Madison Street				9. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JEAN		First M Middle M Last CALDWELL		4. DATE OF DEATH FEB 12 19 61		Month FEB Day 12 Year 19 61		9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) 88 yrs. Months 88 Days 88 Hours 88 Min. 88		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/10/1872		11. BIRTHPLACE (County & State, or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Caldwell				14. MOTHER'S MAIDEN NAME Mary Donahue				Address Arlington, Va. 4226 Columbia Pike,			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 357-03-6072				17. INFORMANT David Caldwell			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Failure DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis causing the underlying cause last, (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH sudden				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year 12/11 Hour a.m. 19 p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12/11 19 60 to 1/11 19 61 that (I) (we) last saw the deceased alive on 12/19 19 61 , and that death occurred at 12/11 M, from the causes and on the date stated above.											
22a. SIGNATURE Dr. H. H. Holbrook				22b. DATE SIGNED 1/14/61				22c. PHYSICIAN'S NAME (Type) Dr. H. H. Holbrook			
23a. BURIAL, CREMATION, REMOVAL (Specify) 2/14/61				23b. DATE THEREOF 2/14/61				23c. NAME OF CEMETERY OR CREMATORY Springdale Cemetery			
23d. LOCATION (City, town or county) Peoria, Illinois				23e. LOCATION (State) Illinois				23f. LOCATION (Country) U.S.A.			
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.				24a. ADDRESS Wash, DC				24b. DATE FEB 14 61			
25a. REC'D BY REGISTRAR Arthur S. Hines				25b. REGISTRAR'S SIGNATURE Arthur S. Hines				25c. DATE FEB 14 61			



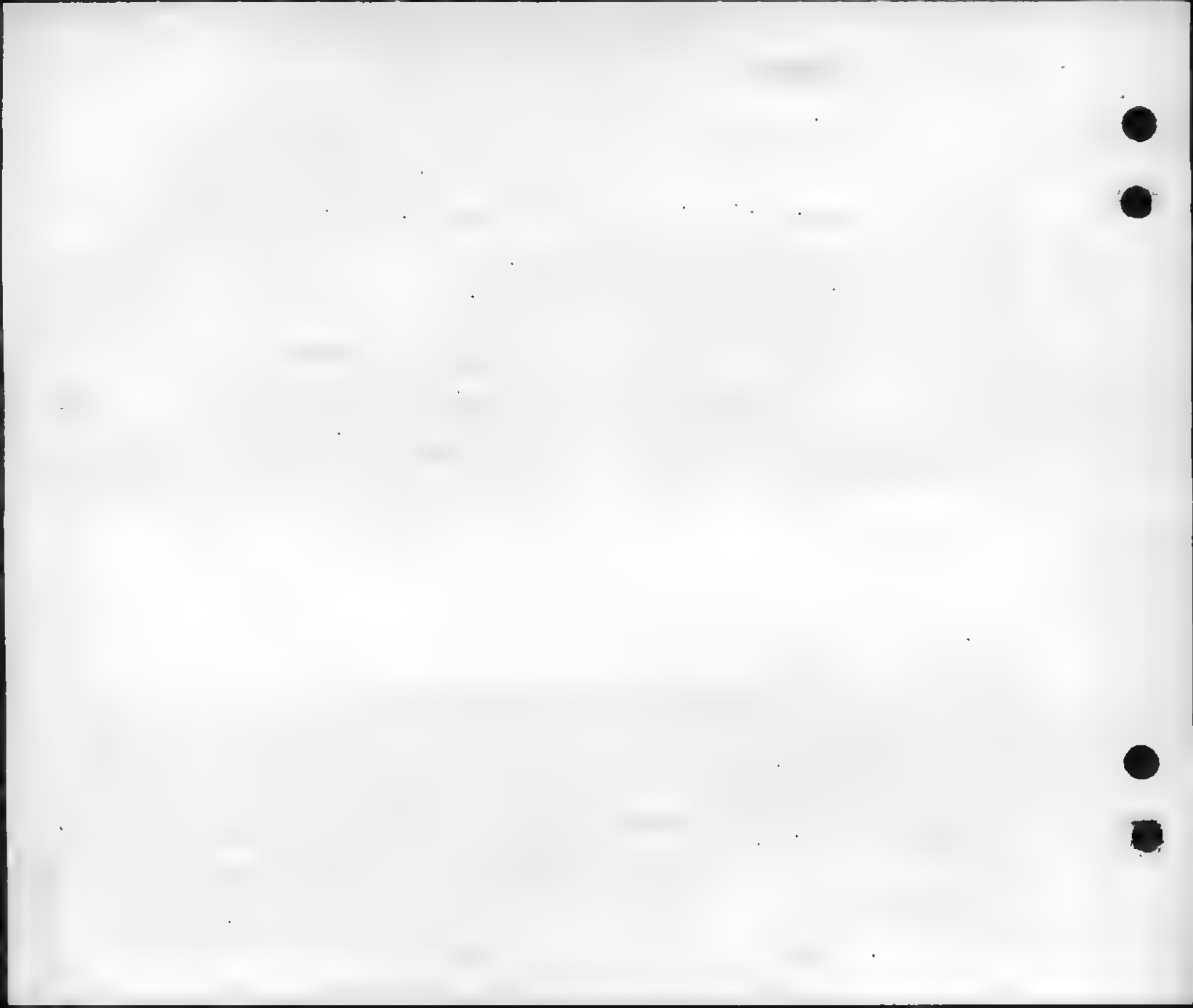
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02025

2048

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Washington D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Md.</u>				c. LENGTH OF STAY IN 1b <u>10 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Besmor Sanat Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George Boone Carpenter</u>				4. DATE OF DEATH <u>Feb. 14 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 7, 1877</u>	
9. AGE (in years, last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>United States</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rancher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
13. FATHER'S NAME <u>George B. Carpenter</u>				14. MOTHER'S MAIDEN NAME <u>Fula Boone</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs. George Carpenter wife</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Bronchopneumonia</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <u>generalized arteriosclerosis</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>April 24, 1960</u> to <u>Feb 14, 1961</u> , that (1) (we) last saw the deceased alive on <u>Feb. 14, 1961</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Wilfred R. Ehrmantraut</u> M.D.				22b. ADDRESS <u>Bethesda, Md.</u>			
22c. PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantraut M.D.</u>				22d. ADDRESS <u>4890 Battery Lane</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>Cremation</u>		<u>2/15/61</u>		<u>Cedar Hill Crematory</u>		<u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				25a. REC'D BY REGISTRAR <u>FEB 17 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



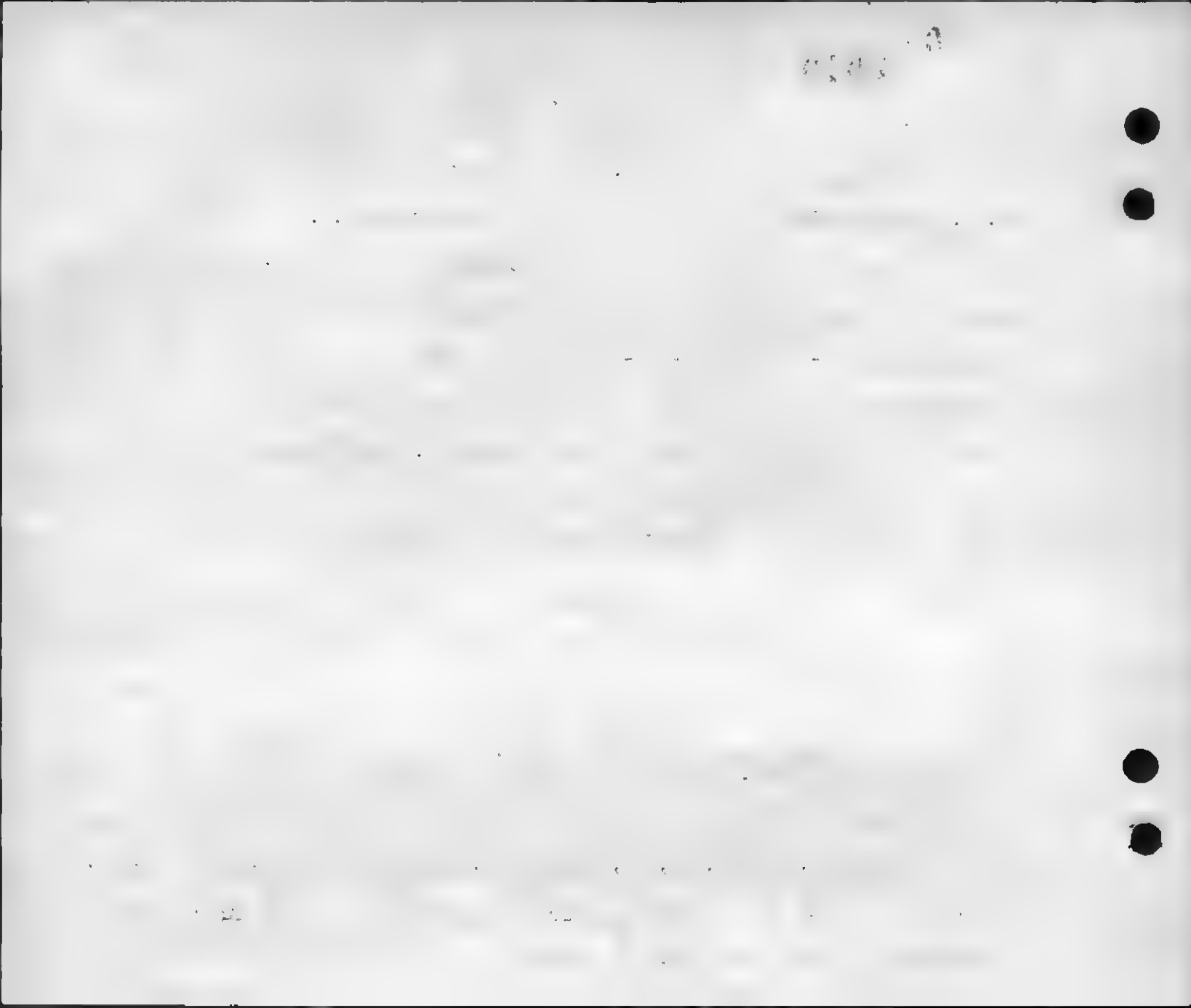
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY				b. COUNTY			
Montgomery				District of Columbia			
b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
Bethesda (Rural)				Washington			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
U. S. Naval Hospital				643 K Street, N.E.			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First Middle Last				Month Day Year			
CARTER				February 21 19 61			
5. SEX				6. COLOR OR RACE			
Female				Negro			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>				8. DATE OF BIRTH			
W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				2-21-61			
9a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired)				9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours Min.			
				yrs. 2 21			
10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (Country & State or foreign country)			
				Maryland USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Stanley W. CARTER				Shirley Ann BAILEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 17. INFORMANT Address			
No				(F) Stanley W. Carter, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a)				IMMATUREITY			
762 - DUE TO				ATELECTASIS, CONGENITAL			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b) DUE TO			
				(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (his/her) attended the deceased from Feb. 21, 1961, to Feb. 21, 1961, that (I) (we) saw the deceased alive on Feb. 21, 1961, and that death occurred at 11 PM, from the causes and on the date stated above.				22b. DATE SIGNED 2-22-61			
22a. SIGNATURE Fred W. Grello				22c. PHYSICIAN'S NAME (Type) Fred W. GRELLO, LT, MC, USN			
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2-25-61			
23c. NAME OF CEMETERY OR CREMATORY National Harmony Memorial Pk.				23d. LOCATION (City, town or county) Prince George, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Palmer Funeral Home, 412 H St., NE, WashDC				25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE FEB 27 '61			

P. Palmer



FOR STATE
HEALTH DEPT.

TO DEPUTY DIRECTOR: This certificate should be executed within 24 hours after death. If any of the above information is not known, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02027

2050

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gaithersburg
c. LENGTH OF STAY IN 1b 20 YEARS
d. NAME OF HOSPITAL, OR INSTITUTION (if not in hospital, give street address) 12 Dear Park Drive

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE md b. COUNTY Monty
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gaithersburg
d. STREET ADDRESS 12 Dear Park Dr

3. NAME OF DECEASED (Type or print) John S. Carter
4. DATE OF DEATH Feb 2 1961

5. SEX male 6. COLOR OR RACE white 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 4-26-1895 9. AGE (In years last birthday) 65 yrs. IF UNDER 1 YEAR: Months 0 Days 0 IF UNDER 24 HRS.: Hours 0 Min. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer 10b. KIND OF BUSINESS OR INDUSTRY NURSERY 11. BIRTHPLACE (State or foreign country) md 12. CITIZEN OF WHAT COUNTRY? U.S.E.

13. FATHER'S NAME John Franklin Carter 14. MOTHER'S MAIDEN NAME Annie E. Damude

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. unknown 17. INFORMANT Elizabeth A. Dove Gaithersburg, Md. Address _____

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion
Conditions, if any, which gave rise to immediate cause (b) _____
(a), stating the underlying cause last. (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____

20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. _____ 19 _____ 20d. INJURY OCCURRED While ☐ at work Not While ☐ at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____

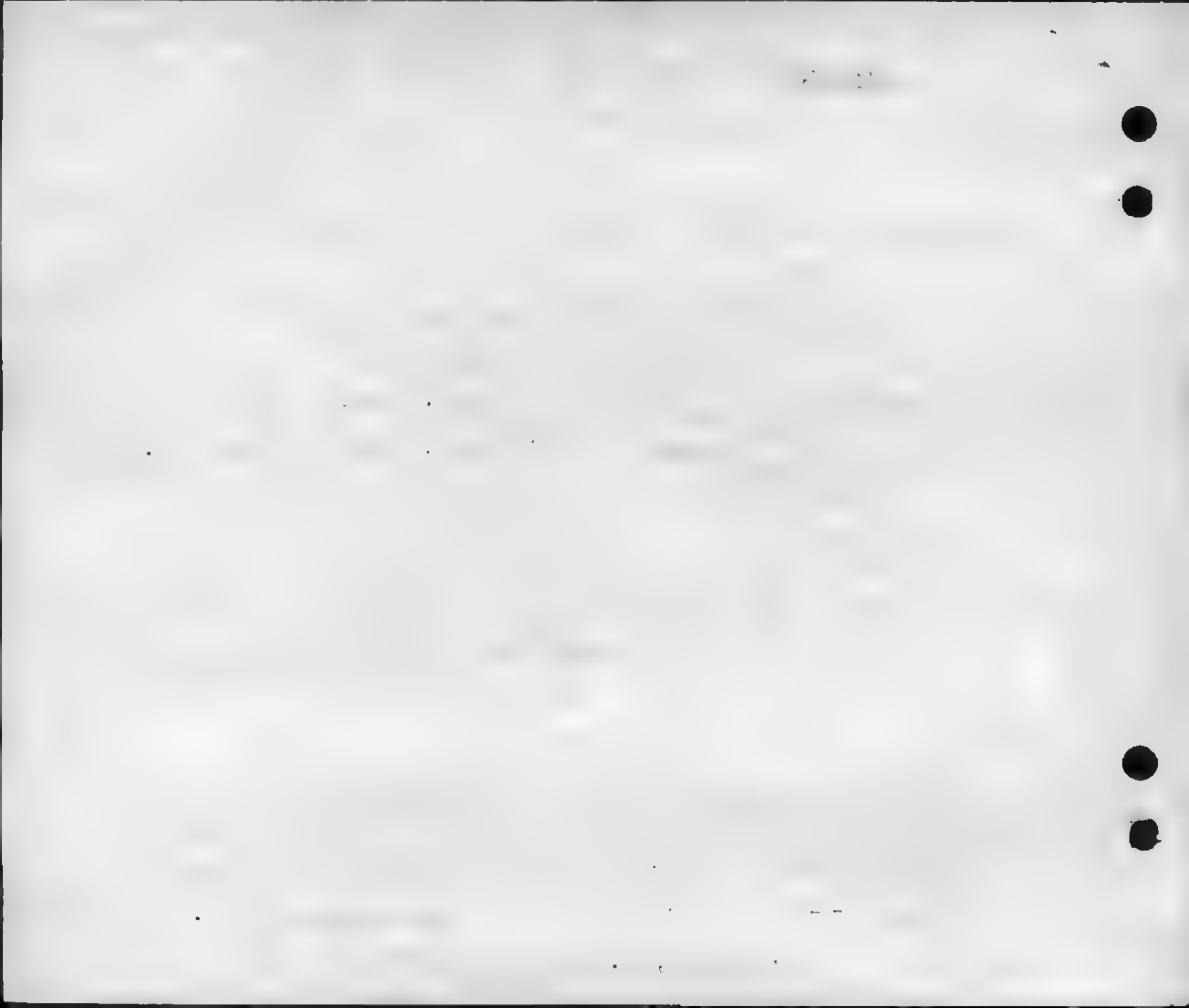
21 I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschart M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 2-2-61
EXAMINER'S NAME (Type) FRANK J. Broschart DEPUTY MEDICAL EXAMINER ☒ Address (Street, city, town, or county) _____

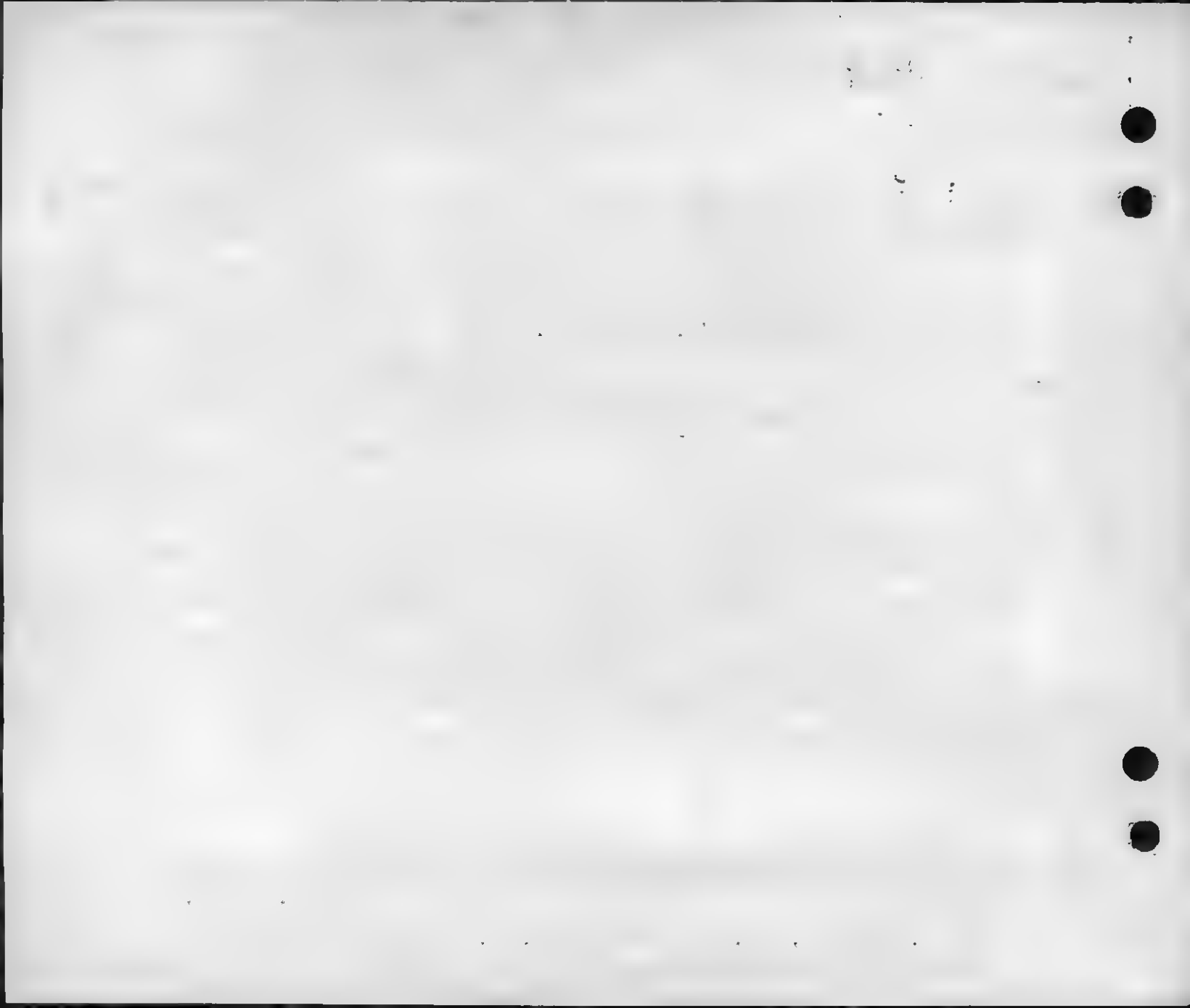
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 2-4-61 22c. NAME OF CEMETERY OR CREMATORY Forest Oak 22d. LOCATION (City, town, or country) Gaithersburg, Md. (State) _____

23. FUNERAL DIRECTOR Francis J. Barber ADDRESS Eatonville, Md. 24a. REC'D BY REGISTRAR FEB 6 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MEDICAL CERTIFICATION



Arthur L. Krauss



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

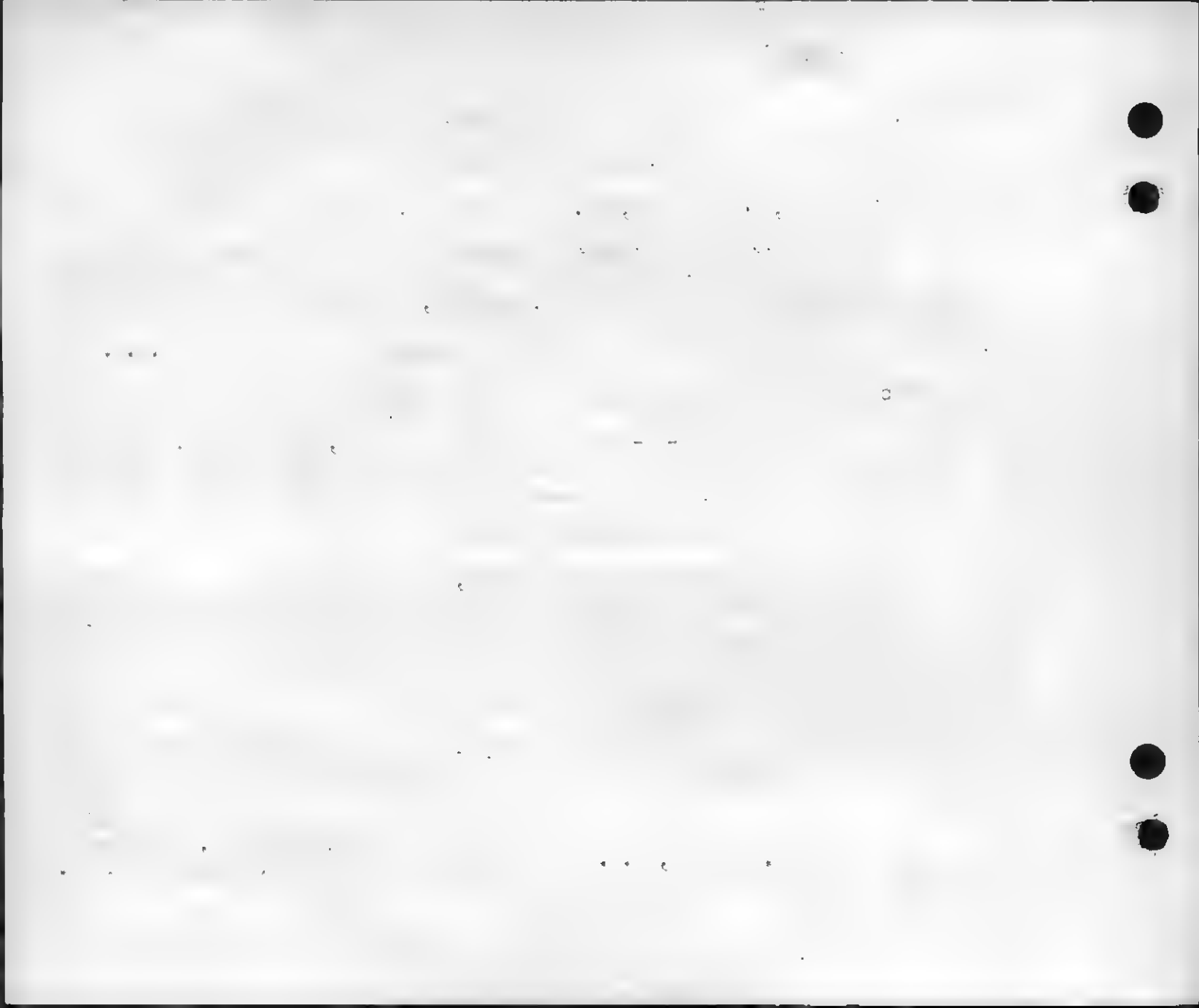
VR A15 (4)
15M 9/59

2052

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02023

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 26 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield d. STREET ADDRESS Route # 1, Box 519 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lottie Elizabeth Chapman		4. DATE OF DEATH Month Day Year February 6 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 30, 1917
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME James Evans		14. MOTHER'S MAIDEN NAME Etta Parker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 218-20-6054	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute respiratory insufficiency secondary to pneumonia and atelectasis DUE TO Chronic pulmonary disease (b) Rheumatic heart disease, Mitral Stenosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH hours years years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 11 19 61 to February 6 19 61 , that (I) (we) last saw the deceased alive on February 6 19 61 , and that death occurred on 2:28 PM from the causes and on the date stated above.			
22a. SIGNATURE James L. Talbert M.D. 22c. PHYSICIAN'S NAME (Type) James L. Talbert, M.D.		22b. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL OR CREMATION MAINTAINED		23b. DATE THEREOF 2-10-61	
23c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cem		23d. LOCATION (City, town, or county) (State) Hopewell, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons Main St. Crisfield, Md.		25a. REC'D BY REGISTRAR DATE FEB 9 '61	
		25b. REGISTRAR'S SIGNATURE C. L. S. K. and	



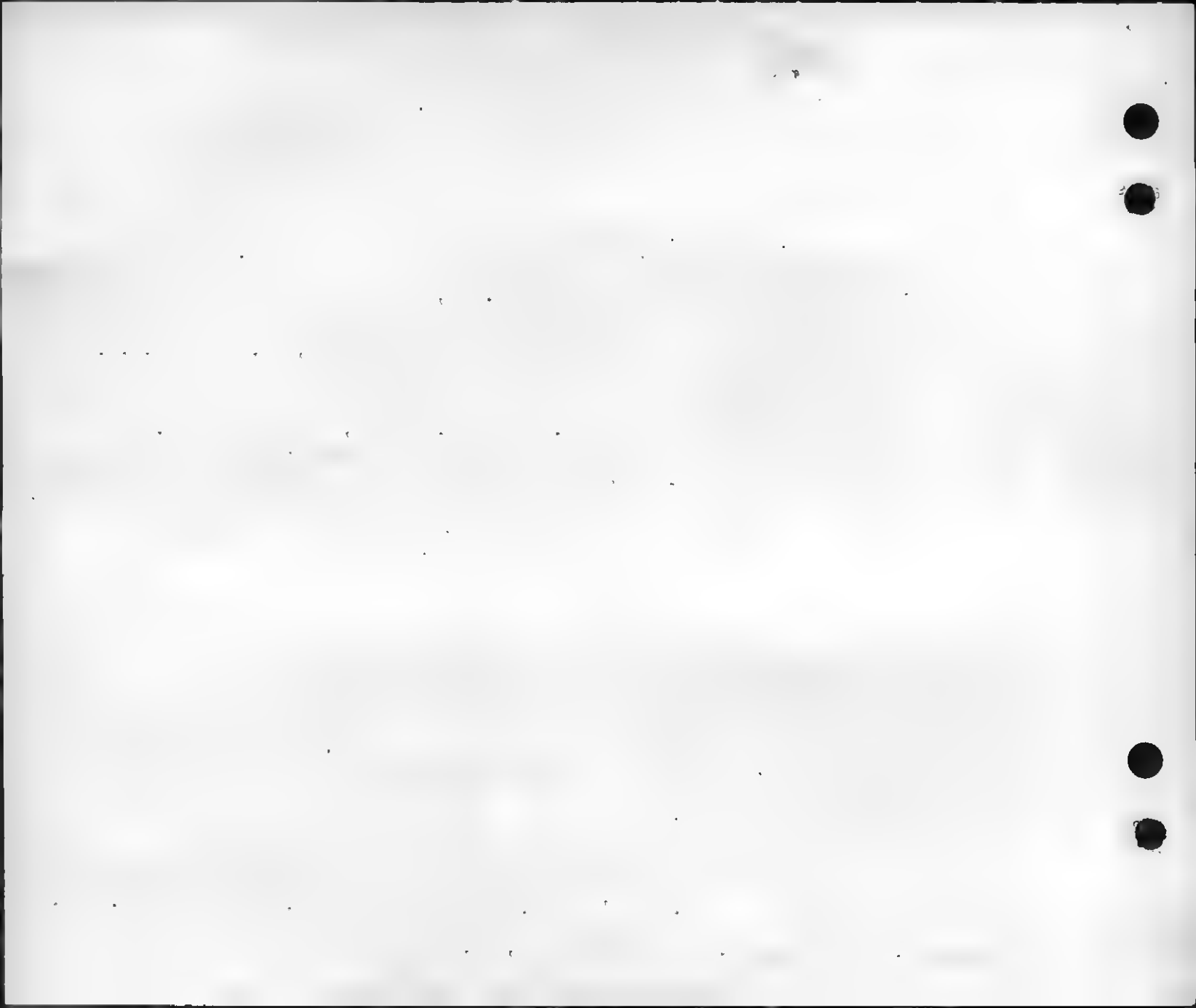
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

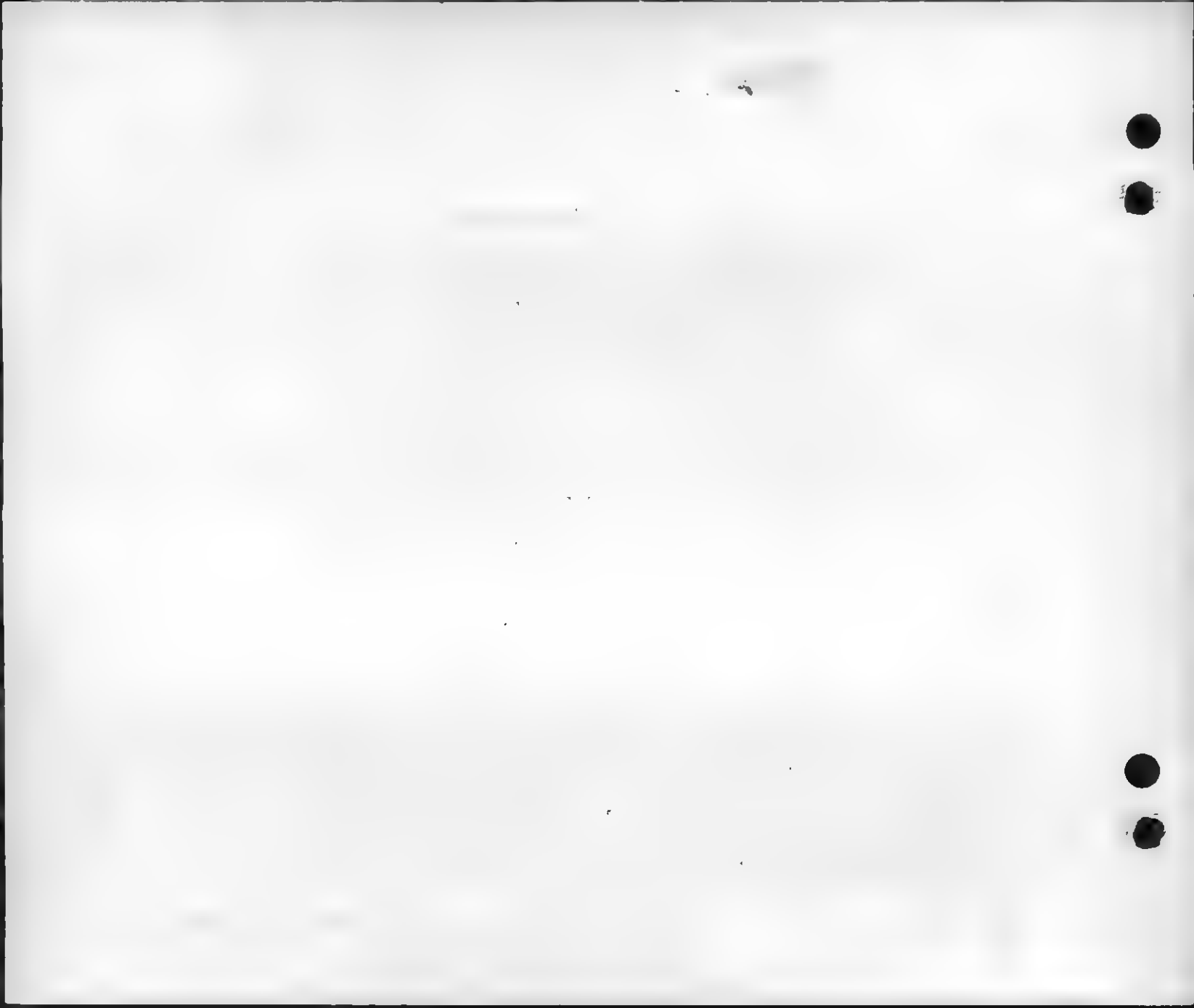
VR A15 (4)
15M 9/59

1
2053
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02050

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b COLESVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL		d. STREET ADDRESS 16 GLENMONT ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HELEN Middle FAWCETT Last CISSEL		4. DATE OF DEATH Month FEB. Day 12 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 31, 1885
9. AGE (In years lost birthday) 76 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MONTGOMERY COUNTY, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LLOYD FAWCETT		14. MOTHER'S MAIDEN NAME ELLA MARLOW	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service, NONE)	
17. INFORMANT Mr. Truman R. Cissel, 16 Glenmont Rd. Colesville, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Myocardial infarction + 20.1 DUE TO Rupture Atheromatous Plaque ant. Coronary artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arterio Sclerosis (c) Many years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 hours 4 hours Many years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1960 to Feb. 12, 1961 , that (i) (we) last saw the deceased alive on Feb. 12, 1961 , and that death occurred at 11:30 AM , from the causes and on the date stated above			
22a. SIGNATURE Merrill M. Cross		22b. DATE SIGNED 2/13/61	
22c. PHYSICIAN'S NAME (Type) MERRILL M. CROSS		22d. ADDRESS 8248 Neogia ave, Silver Spring, Maryland	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/15/61	
23c. NAME OF CEMETERY OR CREMATORY St. Mark's Epis. Church Cemetery		23d. LOCATION (City, town, or county) (State) Fairland, Montgomery Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, INC.		ADDRESS SILVER SPRING, MD.	
25a. REC'D BY REGISTRAR DATE FEB 16 '61		25b. REGISTRAR'S SIGNATURE C. L. K. K. K.	





Page 4
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director.
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

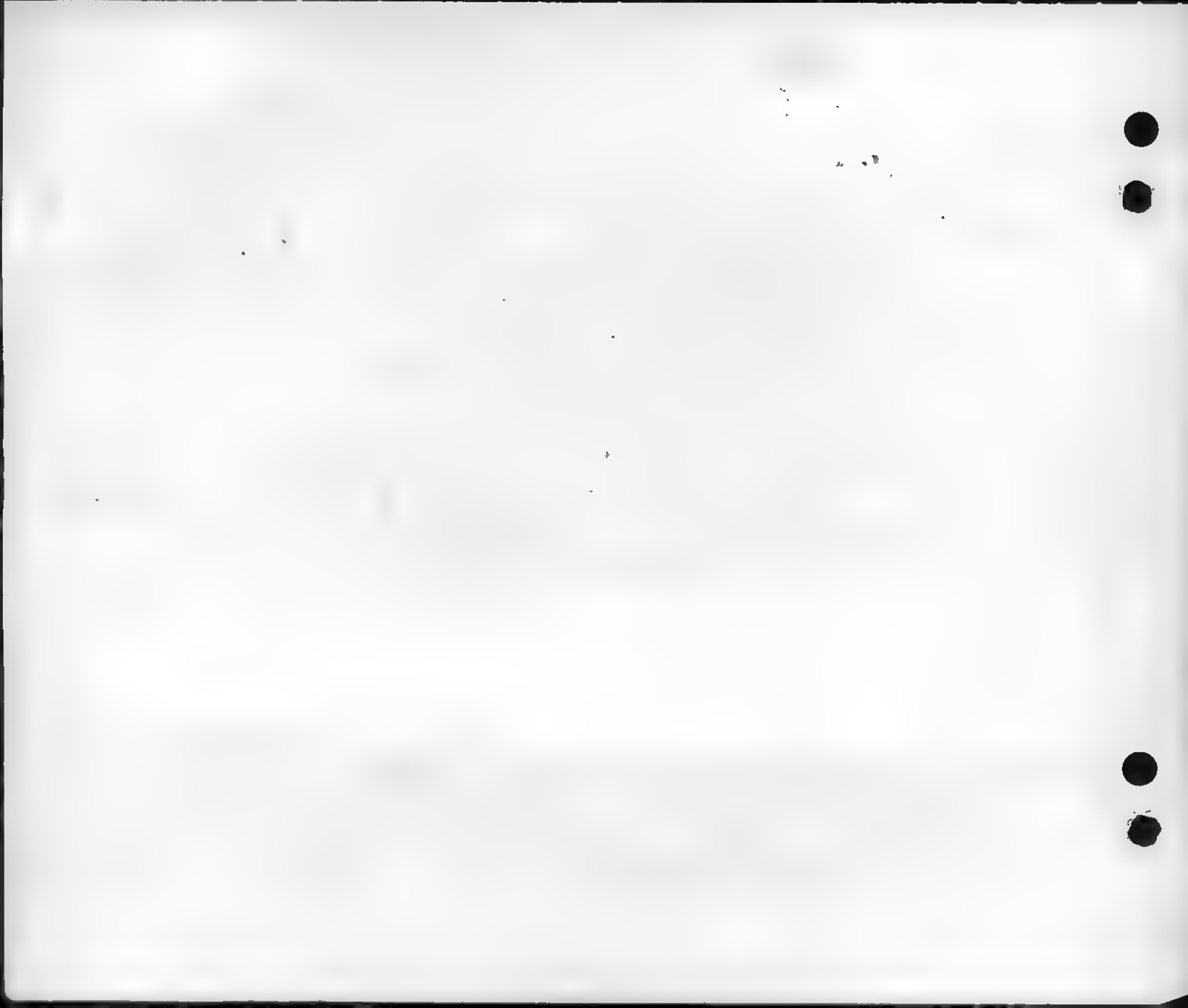
DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2055

CERTIFICATE OF DEATH

02052

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4857 BATTERY LANE</u>		d. STREET ADDRESS <u>4857 BATTERY LANE</u>	
3. NAME OF DECEASED (Type or print) <u>STANLEY MARQUYS CLANCEY</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 22 1887</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES MAN</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MARK CLANCEY</u>		14. MOTHER'S MAIDEN NAME <u>NEIL MULLIN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>WIFE</u> <u>MARIE W. CLANCEY</u>		Address <u>SAME - 2 D</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Floor of Mouth</u> <u>143X</u> DUE TO <u>metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Pneumonia</u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u> <u>@ 1 wk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1960</u> to <u>February 1961</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>2-18</u> 19 <u>61</u> , and that death occurred at <u>1:43</u> PM, from the causes and on the date stated above			
22a. SIGNATURE <u>Bernard A Fitzgerald</u>		22b. DATE SIGNED <u>Feb 21 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A FITZGERALD</u>		22d. ADDRESS <u>217 UNIV. BLVD E. S.S. MD 2-21-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>FEB 24 61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>EVANSTON</u> <u>ILL</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>DeVol Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Washington W.D.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>		DATE <u>FEB 27 '61</u>	



Page 4
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director.
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2056
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural) c. LENGTH OF STAY IN lb 69 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Virginia b. COUNTY Fredricksburg c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 804 Adams d. STREET ADDRESS 804 Adams e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Jack CLIFFORD		4. DATE OF DEATH Month Day Year February 12 1961	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-13-1887
9. AGE (In years lost b rthday) 73 yrs		10. IF UNDER 1 YEAR Months Days Hours Min 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11. BIRTHPLACE (State or foreign country) New Mexico		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John CLIFFORD		14. MOTHER'S MAIDEN NAME Clara Belle EASLY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWI & II	
17. INFORMANT (W) Mrs. Maude F. Clifford, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic pyelonephritis DUE TO (c) 14 year INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 5, 1960 to Feb. 12, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Feb. 12, 1961 , and that death occurred at 5A. M. from the causes and on the date stated above.			
22a. SIGNATURE William P. Baker		22b. DATE SIGNED 2-12-61	
22c. PHYSICIAN'S NAME (Type) William P. Baker, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 2-13-61		23b. DATE THEREOF 2-13-61	
23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City, town, or county) (State) Fredericksburg Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey		25a. REC'D BY REGISTRAR FEB 14 '61	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

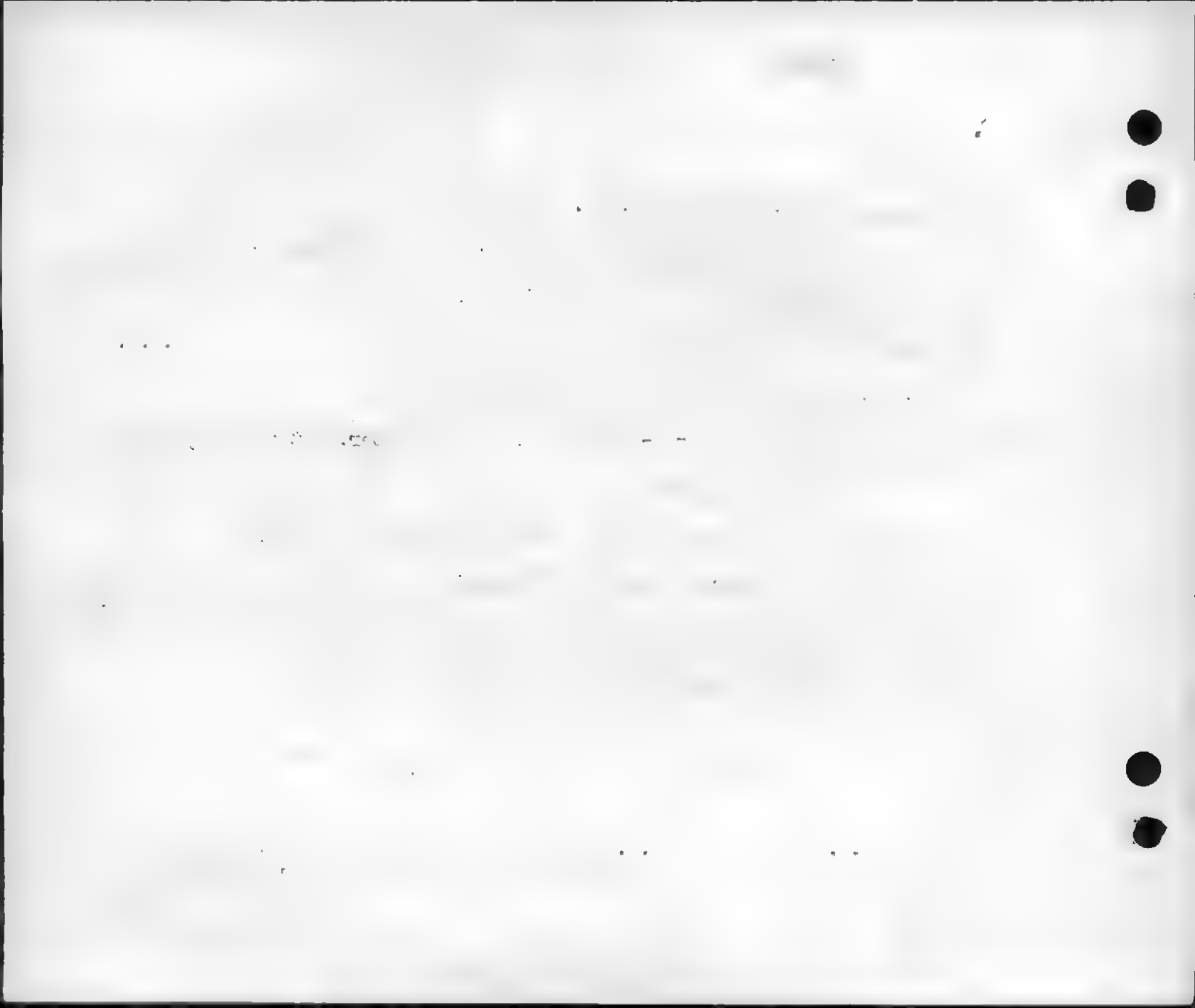
2057

CERTIFICATE OF DEATH

02054

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Kentucky b. COUNTY Y			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 49 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The clinical Center, Bethesda 14, Md.				e. STREET ADDRESS Box 391			
3. NAME OF DECEASED (Type or print) First Chester Middle (None) Last Combs				4. DATE OF DEATH Month February Day 17 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 9, 1926	
9. AGE (In years last birthday) 34 yrs.		10. IF UNDER 1 YEAR Months 5 Days 1 Hours 1 Min.		11. IF UNDER 24 HRS. Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner				10b. KIND OF BUSINESS OR INDUSTRY Mining		11. BIRTHPLACE (State or foreign country) Kentucky	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Combs				14. MOTHER'S MAIDEN NAME Sallie Banks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give year or dates of service) WW II				16. SOCIAL SECURITY NO. 403-22-5791		17. INFORMANT The Medical Records Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypoglycemia 204.3 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Massive infiltration of pancreas by leukemia DUE TO (c) Acute lymphocytic leukemia							
INTERVAL BETWEEN ONSET AND DEATH 5 Days 1 Year 1 Year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from December 30, 1960 to February 17, 1961 , that (I) (we) last saw the deceased alive on February 17, 1961 , and that death occurred at 5:50 PM from the causes and on the date stated above.							
22a. SIGNATURE R. E. Rieselbach				22b. DATE SIGNED 2/18/61			
22c. PHYSICIAN'S NAME (Type) R.E. Rieselbach M.D.				22d. ADDRESS The Clinical Center National Institutes Of Health Bethesda 14, Maryland			
23a. BURIAL OR CREMATION REMOVAL (Specify) removal				23b. DATE THEREOF 2/18/61			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State) Whitesburg, Kentucky			
24. FUNERAL DIRECTOR'S SIGNATURE St. Hines Co 2901 14th NW				25a. REC'D BY REGISTRAR DATE FEB 20 '61			
25b. REGISTRAR'S SIGNATURE Arthur S. Hines							

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A1SME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH															
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
2058 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02035															
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (outside of corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b. <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Saint Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> (Chillum) 1-2 d. STREET ADDRESS <u>805 Sheridan St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Louis</u> 4. DATE OF DEATH <u>2</u> <u>1</u> <u>19 61</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>6-25-10</u> 9. AGE (In years last birthday) <u>50</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard Fed Beau Engraving and Printing</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Trenton New Jersey American</u> 11. BIRTHPLACE (State or foreign country) <u>Hyattsville</u> 12. CITIZEN OF WHAT COUNTRY? <u>American</u>							
13. FATHER'S NAME <u>Domenic Commiso</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>Yes</u> 16. SOCIAL SECURITY NO. <u>?</u> 17. INFORMANT <u>Mrs Josephine Commiso</u> Address <u>805 Sheridan St.</u>				14. MOTHER'S MAIDEN NAME <u>Mary Feronni</u> Address <u>Hyattsville</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct (left)</u> <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Stroke</u> (c) <u>Stroke</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				22b. DATE THEREOF <u>2/4/61</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>				22d. LOCATION (City, town, or country) (State) <u>Prince Georges, Md.</u>			
23. FUNERAL DIRECTOR <u>A. Hines</u> ADDRESS <u>2901 14th NW</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 2 '61</u>				24b. REGISTRAR'S SIGNATURE <u>Onilus S. Kraus</u>				DATE SIGNED <u>2-1-61</u>			

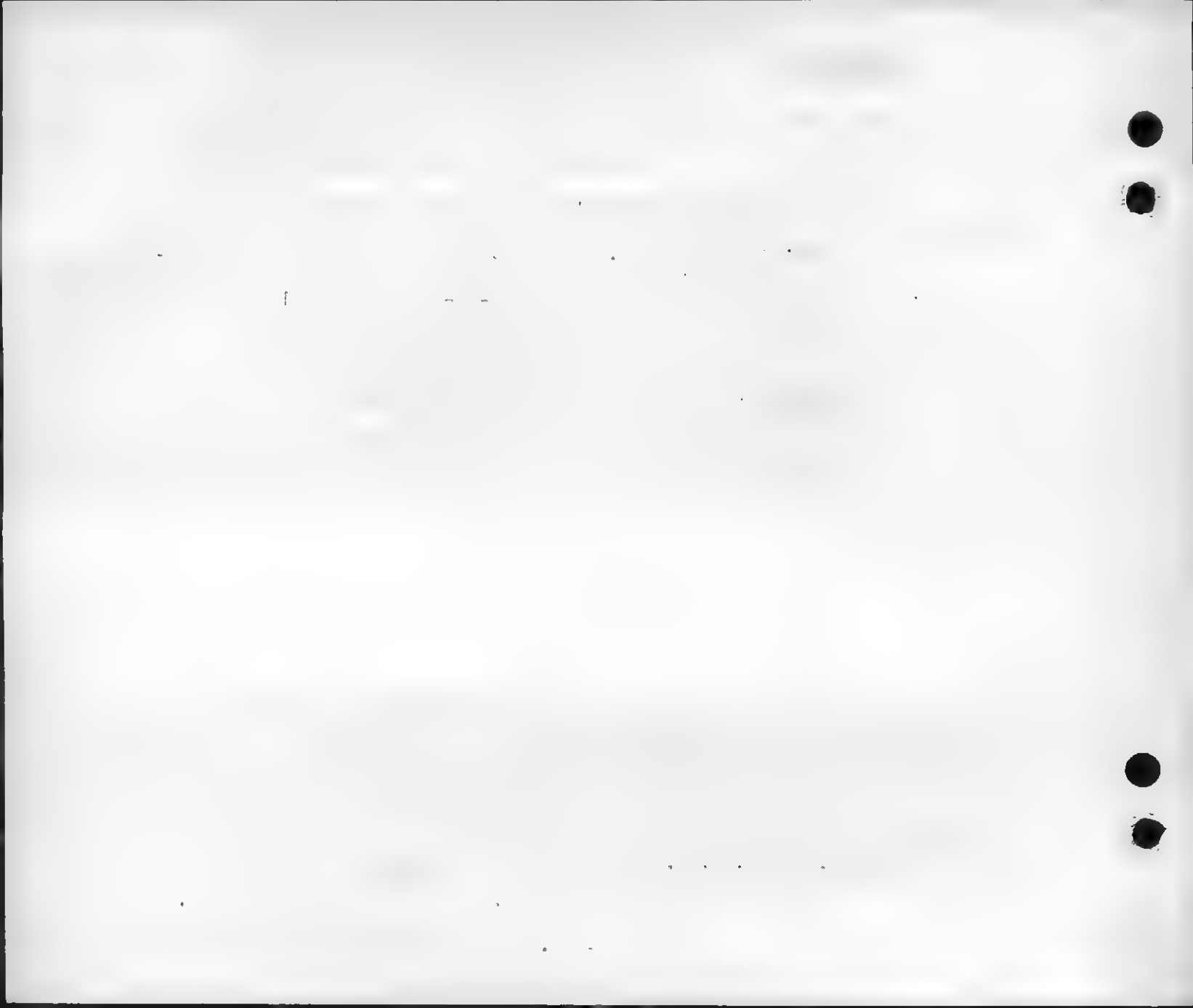


Page 4
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

2059
MARYLAND AND DISTRICT OF COLUMBIA
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 12 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		d. STREET ADDRESS 1 C121, NORWOOD ROAD	
3. NAME OF DECEASED (Type or print) First FRANCES Middle A. Last COOK		4. DATE OF DEATH Month FEBRUARY Day 4 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-12-1889
9. AGE (In years last birthday) 71 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BAKER SEWKITT		14. MOTHER'S MAIDEN NAME LAURA POWELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT HOSPITAL RECORDS		Address OLNEY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331X DUE TO Broncho pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral Hemorrhage DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 days 2 weeks years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960 to Feb 4 , 1961, that (I) (we) last saw the deceased alive on Feb 2 , 1961, and that death occurred at 4:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE R. A. YATES, M. D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) R. A. YATES, M. D.		22d. ADDRESS OLNEY, MARYLAND	
23a. BURIAL CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/7/61	
23c. NAME OF CEMETERY OR CREMATORY Ash Memorial..		23d. LOCATION (City, town, or county) (State) Sandy Spring, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sumner		ADDRESS Rockville, Md.	
25a. REC'D BY REGISTRAR DATE FEB 14 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

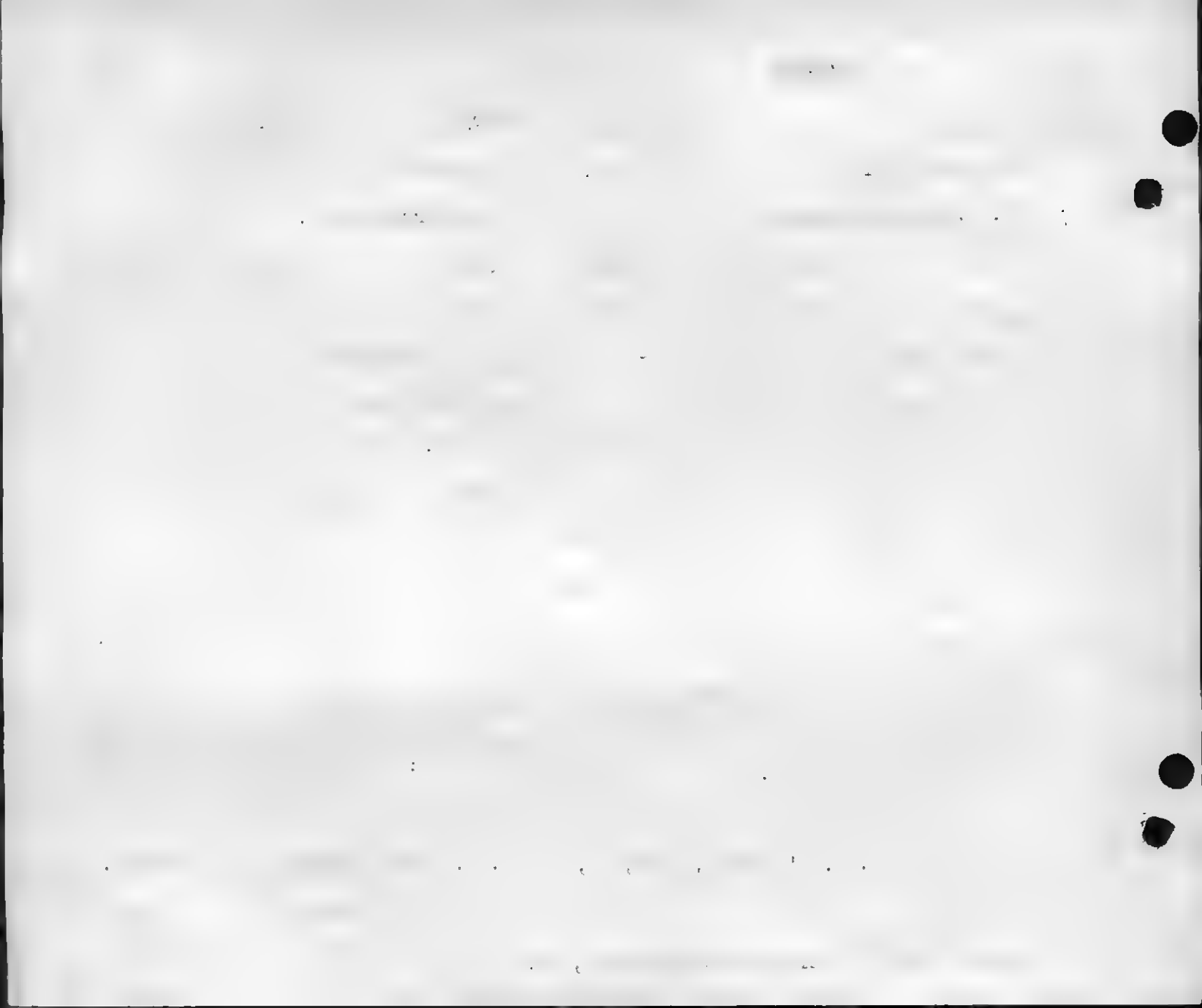
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2060

02057

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>241 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>1611 Farragut Ave.</u>	
13. NAME OF DECEASED (Type or print) <u>Louise Ellis COOK</u>		4. DATE OF DEATH Month <u>February</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH <u>12-3-96</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. BIRTHPLACE County & State, or foreign country <u>West Virginia</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE County & State, or foreign country <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert ELLIS</u>		14. MOTHER'S MAIDEN NAME <u>Mary REYNOLDS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>207-05-9574</u>	
17. INFORMANT <u>(S) Irving R. Cook, same as #2 above</u>		Address <u>#2 above</u>	
18. CAUSE OF DEATH [Enter on only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>200.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Leukemia</u> (c) <u>Advanced Generalized Lymphosarcoma</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH <u>---</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>---</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) (County) (State) <u>---</u>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>June 29, 1960</u> to <u>Feb. 25, 1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Feb. 25, 1961</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>F. H. O'Connell</u>		22b. DATE SIGNED <u>2-26-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>F. H. O'CONNELL, LCDR, MC, USN</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-1-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Park Lawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Rockville Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u>		25a. REC'D BY REGISTRAR <u>FEB 28 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>		DATE <u>---</u>	



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2061

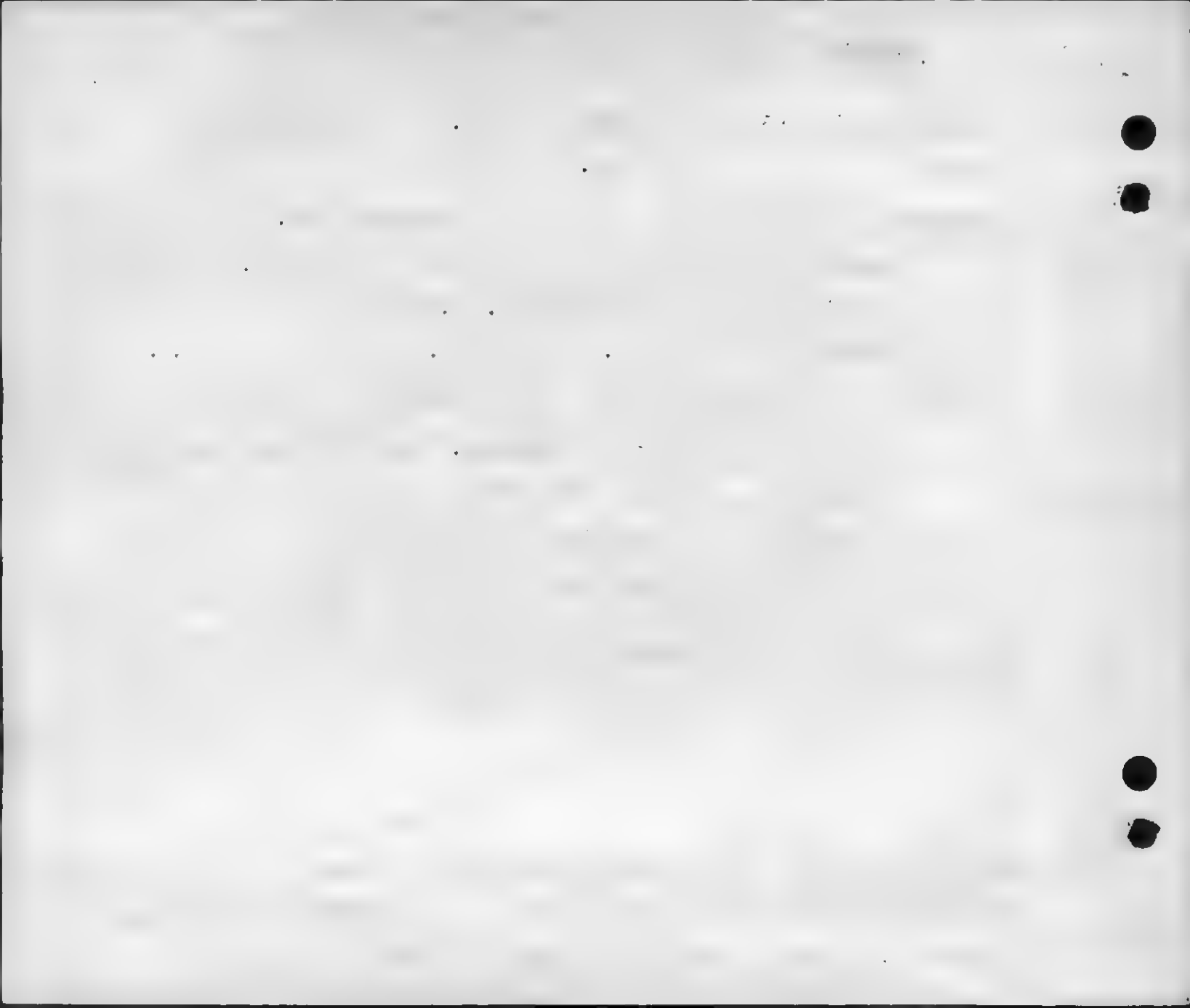
02038

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda Md.</u> c. LENGTH OF STAY IN 1b <u>—</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6600 Bradley Blvd.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Maryland</u> d. STREET ADDRESS <u>6600 Bradley Blvd</u>	
3. NAME OF DECEASED (Type or print) <u>Brunhilde O. Cross</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 23, 1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		9. AGE (In years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Round Valley, Kansas</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Stephen Oakleaf</u> 14. MOTHER'S MAIDEN NAME <u>Ida Wallace</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Mr. John W. Cross</u> Address <u>6600 Bradley Blvd.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> (b) <u>Mitral Insufficiency & Triangular</u> (c) <u>Rheumatic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 1, 1953</u> to <u>2/18, 1961</u> , that (I) (we) last saw the deceased alive on <u>2/10, 1961</u> , and that death occurred at <u>8:45</u> M. , from the causes and on the date stated above.			
22a. SIGNATURE <u>William L. Howell</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>5401 Western Ave NW</u>	
22c. PHYSICIAN'S NAME (Type) <u>William L. Howell</u>		22b. DATE SIGNED <u>2/18/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/22/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Prince George Co. Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Thomas</u> DATE <u>FEB 21 '61</u>	

MEDICAL CERTIFICATION



11



Page 4
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

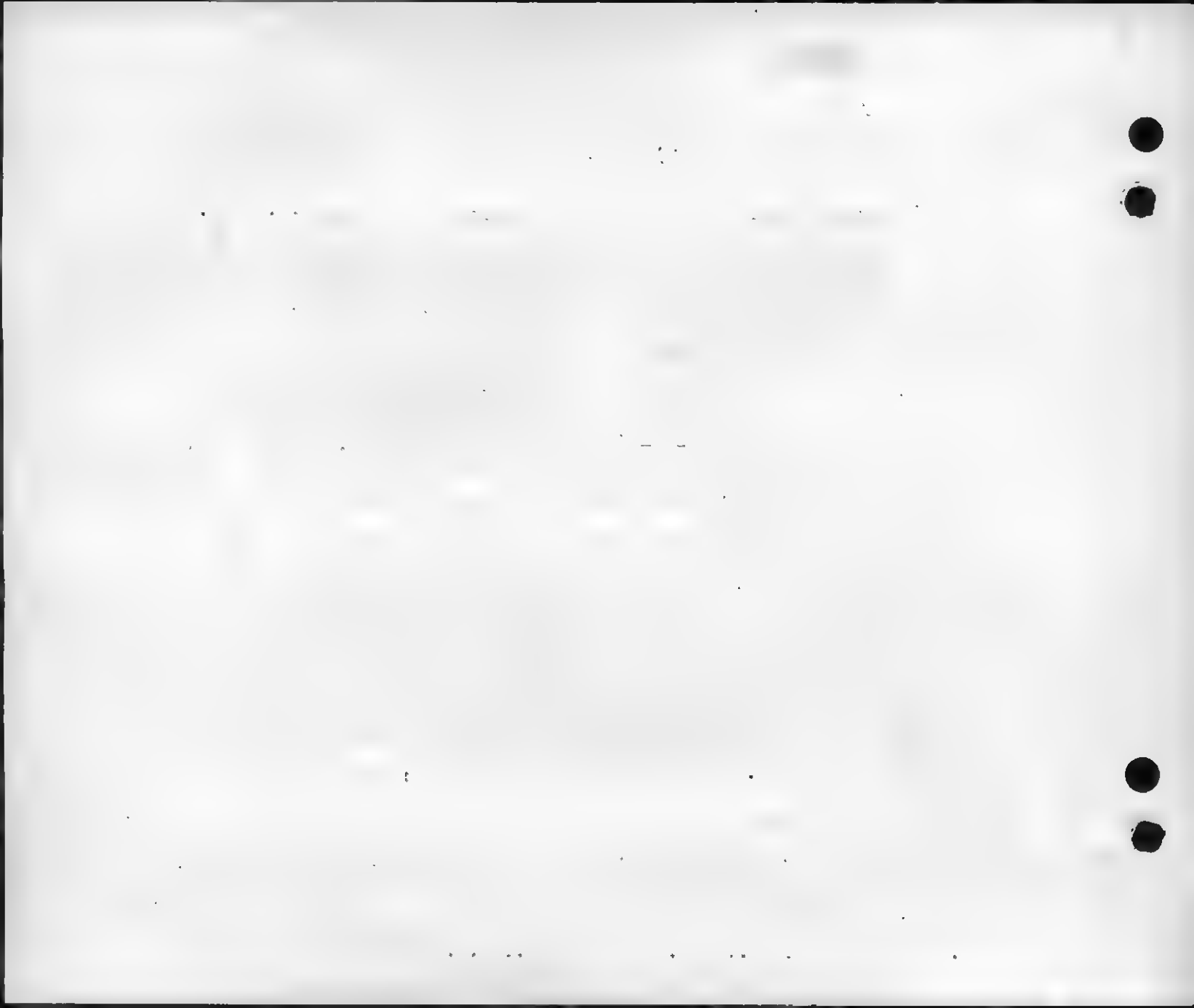
VR A15 (4)
ISM 9/59

2063

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02040

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 183 Days		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE District of Columbia b. COUNTY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		d. STREET ADDRESS 115-16th Street, N.E., Apt. 104							
3. NAME OF DECEASED (Type or print) First Edward		Middle Wilson		Last Culpepper		4. DATE OF DEATH Month February 9,		Day 19 61	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 15, 1914		9. AGE (in years last birthday) 46 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Orderly		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Elijah Culpepper		14. MOTHER'S MAIDEN NAME Edith Wilson							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 577-01-8652		17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe pulmonary edema 191.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) supra diaphragmatic carcinomatosis (c) epidermoid carcinoma of face DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs months 7 10 yrs.						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from August 10, 1960, to February 9, 1961, that (I) (we) last saw the deceased alive on Feb. 9, 1961, and that death occurred 12:39 PM on the causes and on the date stated above		22a. SIGNATURE David T. Crawford		M.D. DAVID T. CRAWFORD, M.D.		22b. DATE SIGNED 2-10-61			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/14/1961		23c. NAME OF CEMETERY OR CREMATORY Wincoln Memorial		23d. LOCATION (City, town, or county) Suitland, Maryland		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE W. Ernest Jarvis Co., Inc. 1432 You St., N.W.		ADDRESS		25a. REC'D BY REG STRAR DATE 14 '61		25b. REGISTRAR'S SIGNATURE Arthur P. ...			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is needed, it should be given in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 2064 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>15 1/2 Fayette st</u>		d. STREET ADDRESS <u>15 1/2 Fayette st</u>	
3. NAME OF DECEASED (Type or print) <u>Fred Turner Cunningham</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Month <u>8</u> Day <u>28</u> Year <u>1911</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR: Months <u>2</u> Days <u>1</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ind.</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Yes. Cunningham</u>		14. MOTHER'S MAIDEN NAME <u>Turner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>116-20-40</u>	
17. INFORMANT <u>Edna Cunningham (wife)</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u> (c) <u>sudden</u> DUE TO (c) <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2/24/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or country) (State) <u>Prince George County, Md.</u>	
23. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		24a. REC'D BY REGISTRAR <u>FEB 24 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE SIGNED <u>2-21-61</u>	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shall be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

(M)

(I)

MEDICAL CERTIFICATION

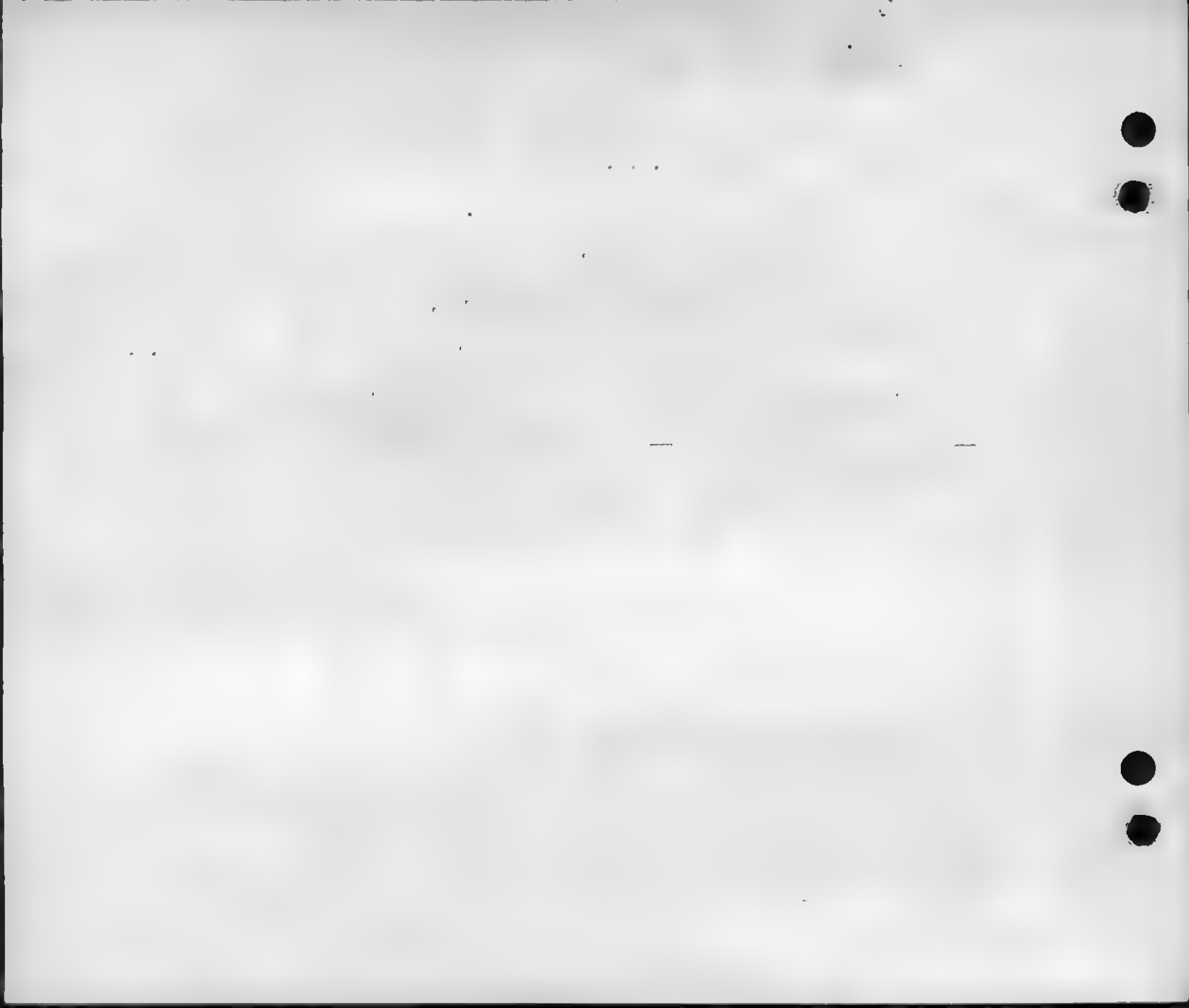
MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>1 hr</u>				d. STREET ADDRESS <u>13914 Mills Ave</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				a. DATE OF DEATH <u>Feb 4</u> 1961			
3. NAME OF DECEASED (Type or print) <u>Charles I Curtis</u>				5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>9-1-24</u>				9. AGE (in years) IF UNDER 1 YEAR <u>36</u> yrs. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Jog Breeder</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u>Kenne' Owner</u>				11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>LUM IRVIN</u>				14. MOTHER'S MAIDEN NAME <u>Viola May Chapman</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW II</u>			
16. SOCIAL SECURITY NO. <u>NO</u>				17. INFORMANT <u>Police record</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage + laceration</u>				DUE TO (b) <u>X</u>				DUE TO (c) <u>X</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted bullet wound Thru skull</u>							
20c. TIME OF INJURY Month, Day, Year <u>7:32 p.m. 2-4 1961</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Auto</u>			
20f. (City or town) <u>Bethesda</u>				20g. (County) <u>Montg</u>				20h. (State) <u>md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2/7/61</u>				22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>			
22d. LOCATION (City, town, or country) (State) <u>Rockville, Md.</u>				23. FUNERAL DIRECTOR <u>John F. ...</u> ADDRESS <u>1313 E. ...</u>				24a. REC'D BY REGISTRAR <u>FEB 9 '61</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>				24c. DATE <u>2-4-61</u>				24d. CHIEF MEDICAL EXAMINER <u>Frank J. Broschart</u>			
24e. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				24f. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				24g. DATE SIGNED <u>2-4-61</u>			

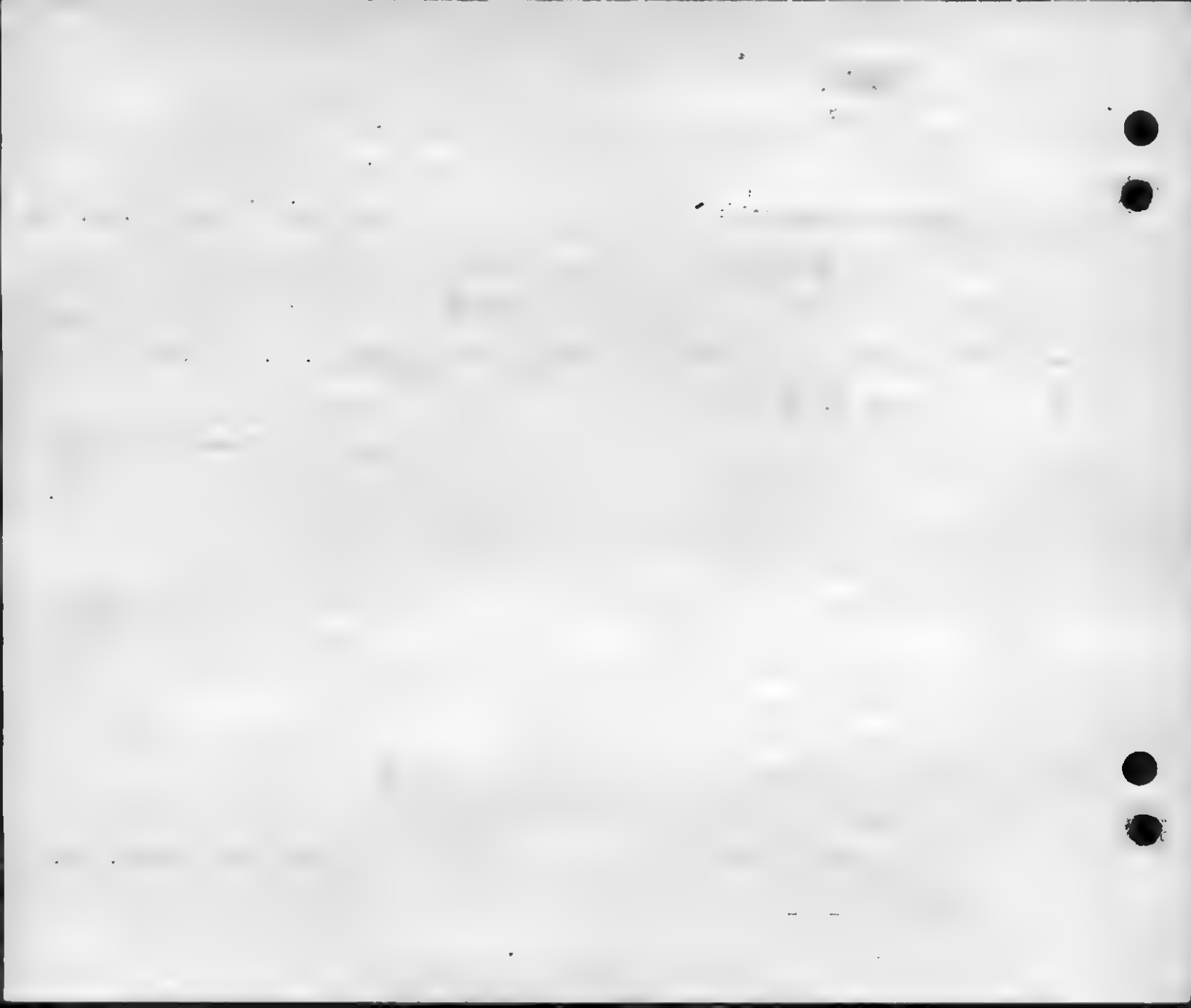


VS. A15ME
5M 7/59

02043

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN b. D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS Rt. 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edna		First Middle Last Lenora Davidson		4. DATE OF DEATH Month Day Year February 4 19 61	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH October 3, 1919		9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Robert Hogsden		14. MOTHER'S MAIDEN NAME Ethel Eastridge	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) —		16. SOCIAL SECURITY NO. —		17. INFORMANT (Husband) Address George Davidson As above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.0 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Boushert		M.D. FRANK J. BOUSHERT		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BOUSHERT		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2-4-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-6-61		22c. NAME OF CEMETERY OR CREMATORY Forest Oak	
22d. LOCATION (City, town, or country) (State) Gaithersburg, Md.					
23. FUNERAL DIRECTOR B. L. Linton		ADDRESS 316 E. Beaman		24a. REC'D BY REGISTRAR DATE FEB 7 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2068

CERTIFICATE OF DEATH

02045

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
c. LENGTH OF STAY IN 1b <u>life</u>		d. STREET ADDRESS <u>17 Oswego Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>residence</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Richard</u> Last <u>Dawes</u>		4. DATE OF DEATH Month <u>February</u> Day <u>20</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W.C.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 9 1875</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cement Finisher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Landscaping</u>	
11. BIRTHPLACE (State or foreign country) <u>Culpepper, VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Howard Dawes</u>		14. MOTHER'S MAIDEN NAME <u>Winnie Ferguson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-14-7426</u>	
17. INFORMANT <u> </u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Internal Hemorrhage Gastric</u> <u>ulcer</u> DUE TO <u>Anemia Nephrosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>gastric Carcinoma</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a.m. <u> </u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Net while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I attended the deceased from <u>July 10, 1960</u> to <u>Feb 20, 1961</u> , that I last saw the deceased alive on <u>Feb 19, 1961</u> , and that death occurred at <u>9:55 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norbeck</u> M.D.		ADDRESS (Street, city or town, state) <u>NORBECK</u> DATE SIGNED <u>2-20-61</u>	
PHYSICIAN'S NAME (Type) <u>WEBSTER SEWELL</u>		<u>SILVER SPRING MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2.25.61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LINCOLN MEM. CEM.</u>		22d. LOCATION (City, town, or county) <u>SUITLAND, MARYLAND</u> (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert F. Young</u> ADDRESS <u>4820 9TH ST., N.W.</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>FEB 24 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

WASHINGTON, D.C.



Page 1
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2069

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02046

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 10 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) California d. STREET ADDRESS Box #5 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Martin Valentine DICKMANN		4. DATE OF DEATH Month Day Year February 16 19 61	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-13-14
9. AGE (In years lost birthday) 47 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin DICKMANN		14. MOTHER'S MAIDEN NAME Bertha FOLKNER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 081-32-5500	
17. INFORMANT (W) Mrs. Anna N. Dickmann, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis, liver, Laennec's DUE TO Candidiasis, if only, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that MD (this hospital) attended the deceased from Feb. 6 12:09PM to Feb. 16 19 61 , that he (we) last saw the deceased alive on Feb. 16 1961 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Paul G. Linaweaver, Jr. M.D.		22b. DATE 2-16-61	
22c. PHYSICIAN'S NAME (Type) Paul G. LINAWEAVER, JR., LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-21-61	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robinson Funeral Home, Leonardtown, Md. ADDRESS		25a. REC'D BY REGISTRAR FEB 24 61 DATE	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



02051

VR A15 (4)
1SM 11/59



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 only should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

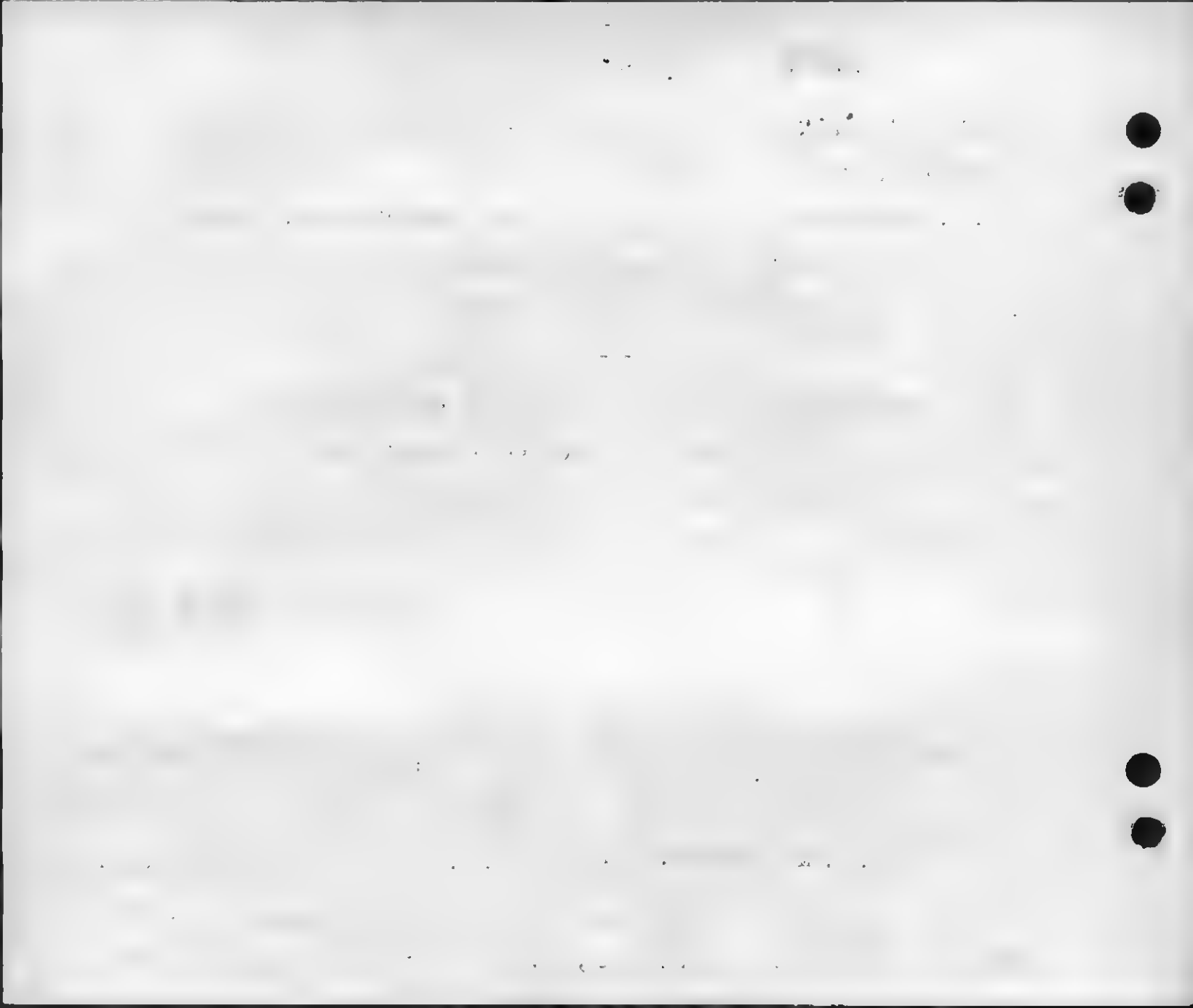
VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2071

02048

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Norfolk</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1018 Rockbridge Ave. - Apt. 162C</u> d. STREET ADDRESS <u>1018 Rockbridge Ave. - Apt. 162C</u>	
3. NAME OF DECEASED (Type or print) <u>Peri Jeanette DILLARD</u>		4. DATE OF DEATH Month <u>February</u> Day <u>26</u> Year <u>1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>1-31-61</u>		9. AGE (In years if UNDER 1 YEAR IF UNDER 24 HRS., last birthday) Months <u>27</u> Days <u>27</u> Hours <u>1</u> Min. <u>27</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTH-PLACE County & State, or foreign country <u>Virginia</u>	
13. FATHER'S NAME <u>John Samuel DILLARD</u>		14. MOTHER'S MAIDEN NAME <u>Dorise Jeanette TRAVIS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>(F) J. S. Dillard, same as #2 above</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGENITAL HEART DISEASE, (TRICUSPID ATRESIA,</u> <u>154</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ATRIAL SEPTAL DEFECT, VENTRICULAR SEPTAL Defect</u> (c) <u>DEFECT</u>	
19. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Feb. 23</u> <u>1961</u> to <u>Feb. 26</u> <u>1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Feb. 26</u> <u>1961</u> , and that death occurred at <u>2:15 PM</u> <u>M</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>J. E. MC CLENATHAN</u> 22c. PHYSICIAN'S NAME (Type) <u>J. E. MC CLENATHAN, CDR, MC, USN</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-28-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) (State) <u>Arlington</u> <u>Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u> 24b. ADDRESS <u>Tyson Wheeler Funeral Home, Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u>Feb 28 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



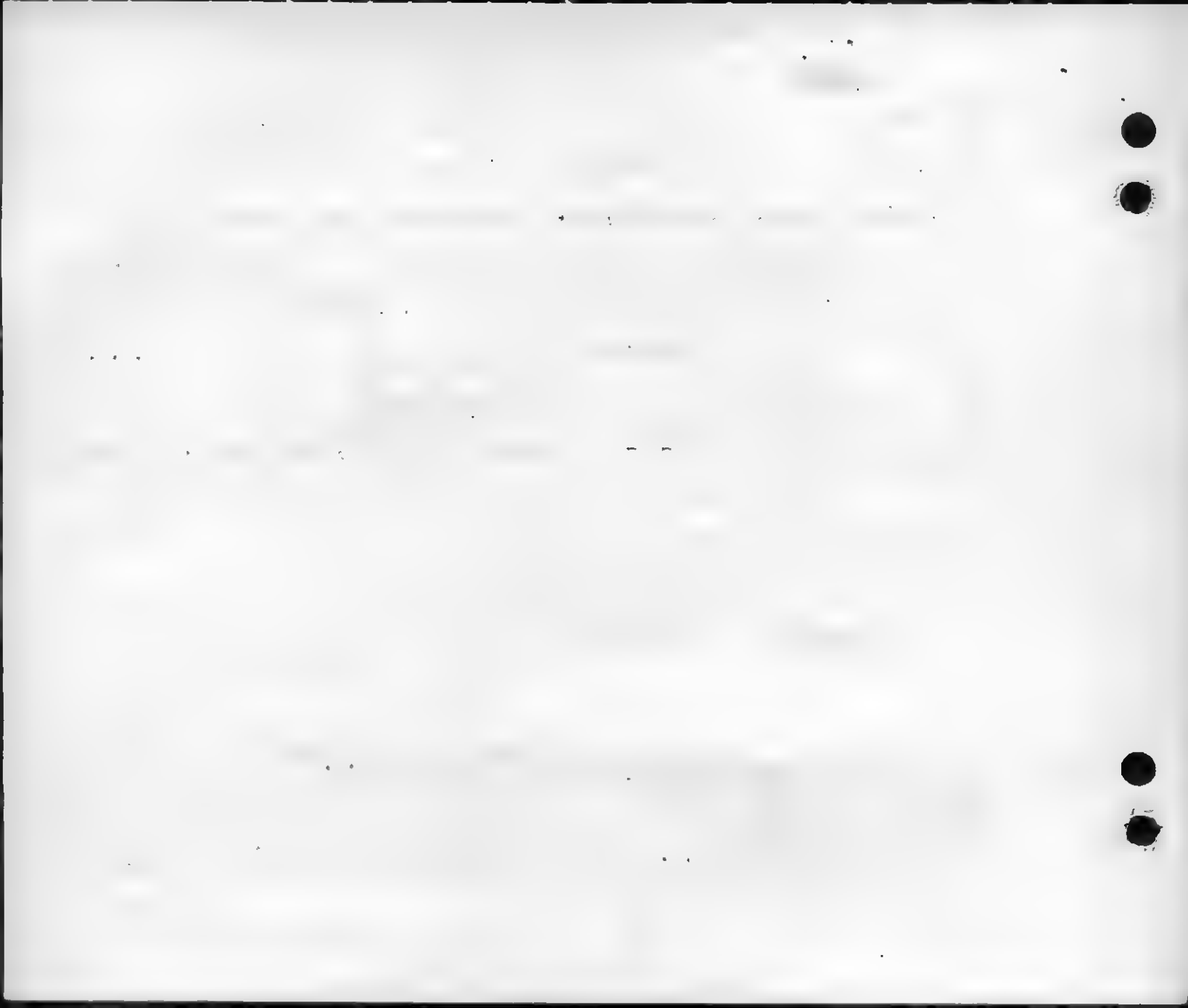
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02043

2072

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Virginia b. COUNTY Henrico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Richmond			
c. LENGTH OF STAY IN 1b 13 Hours				d. STREET ADDRESS 205 South Mulberry Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Theodora Middle Olive Last Downing		4. DATE OF DEATH		Month February Day 15 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 5, 1908		9. AGE (In years last birthday) 53 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Banking		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Maurice Downing				14. MOTHER'S MAIDEN NAME Daisy Redgrove			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 226-07-6840		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Congestion							
DUE TO 170X							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
(b) Carcinoma, Right Breast							10 Years
(c) Carcinoma, Ovary							5 Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Hemopericardium							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from February 14 1961 to February 15 1961 , that (I) (we) last saw the deceased alive on February 15 1961 , and that death occurred at 1:10 a.m. , from the causes and on the date stated above.							
22a. SIGNATURE <i>Martin Nydick</i>				22b. DATE 2/15/61		22c. PHYSICIAN'S NAME (Type) MARTIN NYDICK, M.D.	
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland				22e. ADDRESS		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/17/61		23c. NAME OF CEMETERY OR CREMATORY Blandford Cemetery		23d. LOCATION (City, town, or county) (State) Petersburg, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				25a. REC'D BY REGISTRAR FEB 17 61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND CERTIFICATE OF DEATH

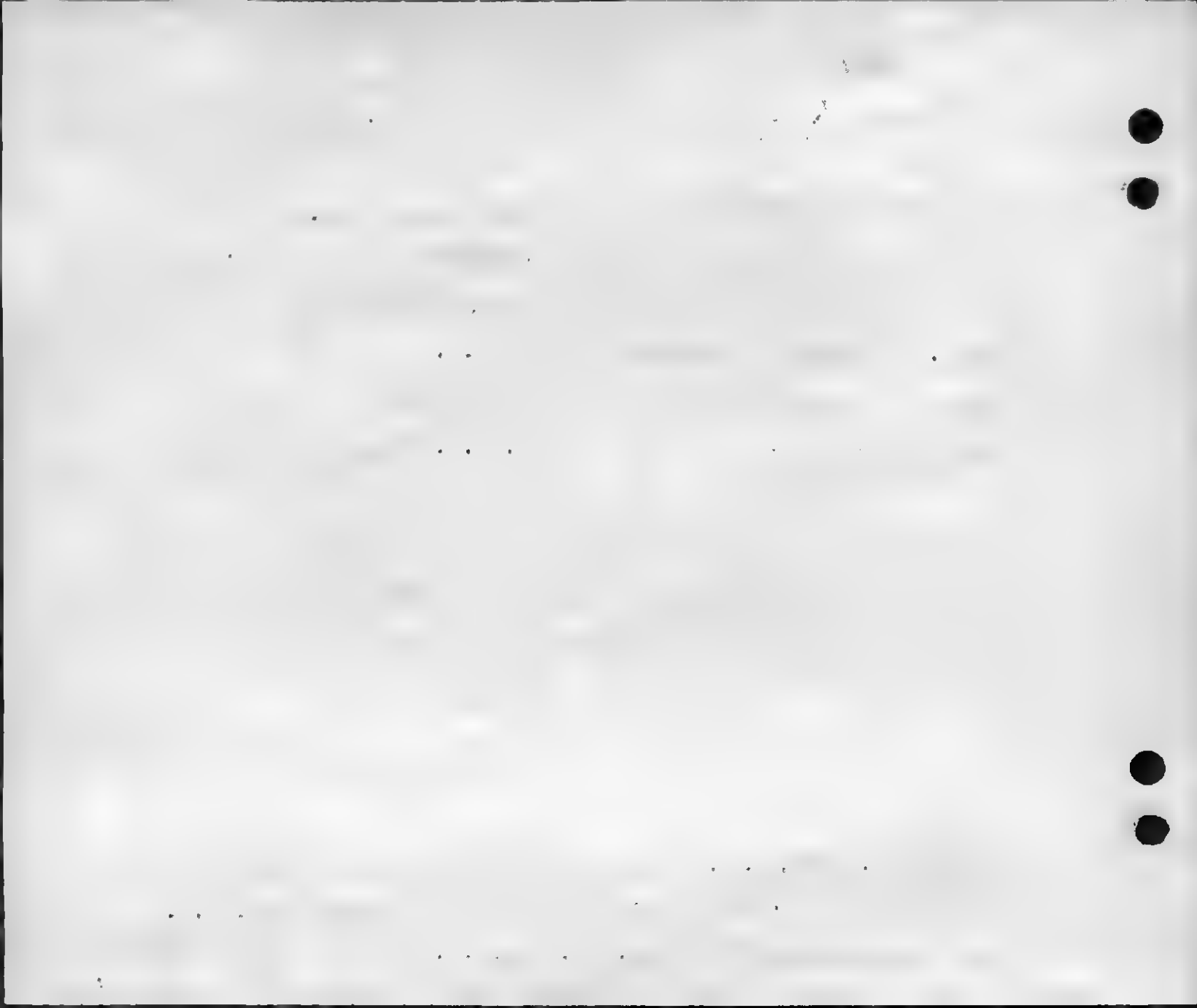
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2073

CERTIFICATE OF DEATH

02050

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fairland c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Fairland Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 47 Bethesda d. STREET ADDRESS 8101 Custer Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CARL Middle AUGUST Last DUEHRING		4. DATE OF DEATH Month Feb. Day 1 Year 19 61	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4 May 1880	
9. AGE (in years last birthday) 80		10. IF UNDER 1 YEAR Months 80 Days 80	
11. IF UNDER 24 HRS. Hours 80 Min. 80		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd. Merchant	
10b. KIND OF BUSINESS OR INDUSTRY Hardware		11. BIRTHPLACE (County & State, or foreign country) D.C.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME August Duehring	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No	
16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Mrs. C.B. Gilpin Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Arteriosclerotic heart disease (c) Generalized arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 22 , 19 57 , to Feb. 1 , 19 61 , that (I) (we) last saw the deceased alive on Jan. 29 , 19 61 , and that death occurred at 2 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Aaron H. Traum		22b. DATE SIGNED Feb. 1 1961	
22c. PHYSICIAN'S NAME (Type) Aaron H. Traum, M. D.		22d. ADDRESS 8237 Georgia Ave Silver Spring Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 4 Feb. 1961	
23c. NAME OF CEMETERY OR CREMATORY Lee's Crematorium		23d. LOCATION (City, town or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		25a. REC'D BY REGISTRAR FEB 2 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Frank			



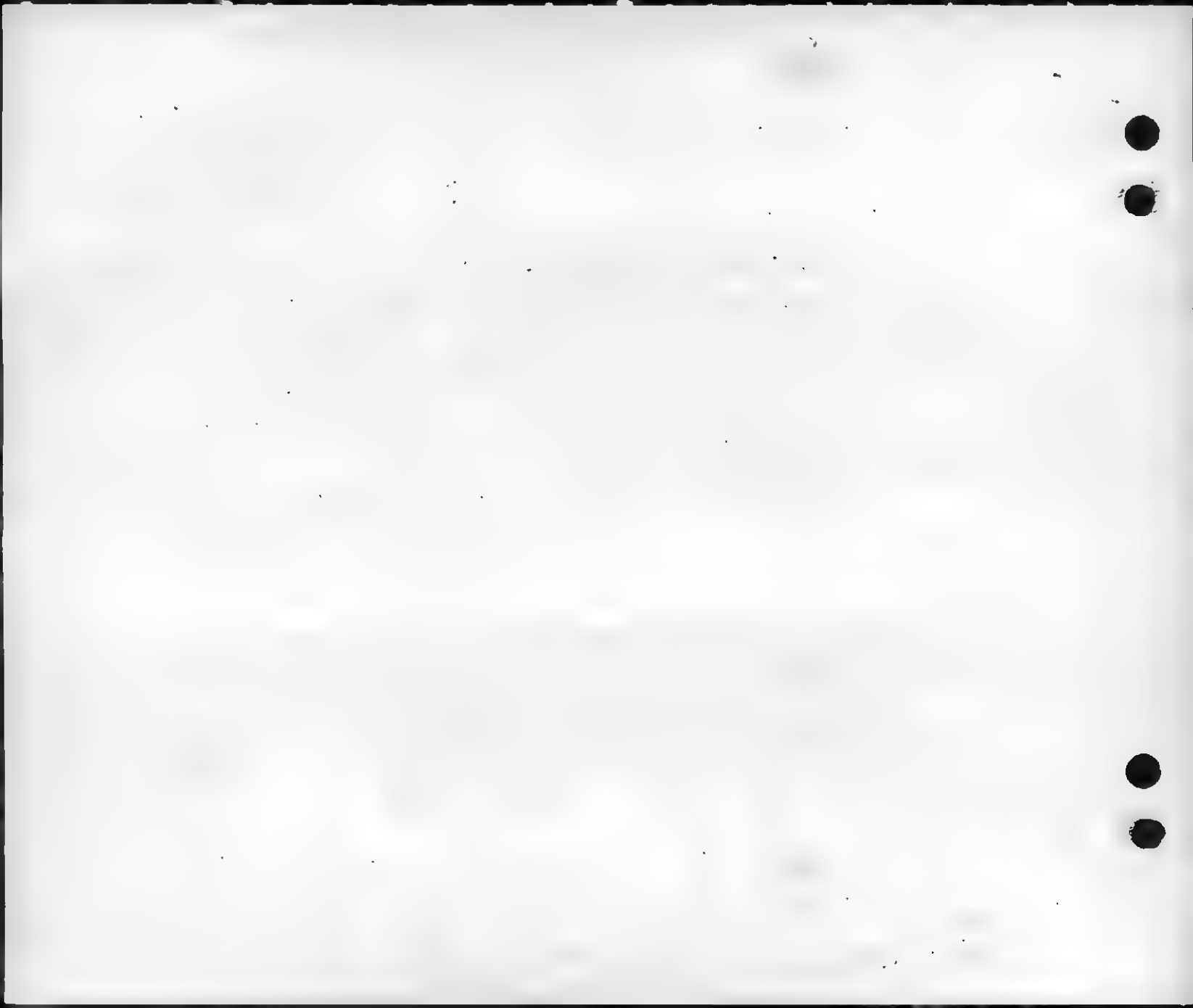
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2074

0205

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Mont.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 13 hrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>			e. STREET ADDRESS <u>4702 - Chestnut St.</u>		
3. NAME OF DECEASED (Type or print) <u>Caraco</u> First <u>G.</u> Middle <u>H.</u> Last <u>Duke</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>6</u> Year <u>1961</u>		
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/15/1936</u>		9 AGE (in years last birthday) <u>67</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Used Car Lot</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Caraco Lee Duke</u>			
14. MOTHER'S MAIDEN NAME <u>Charal Godley</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. <u>577-10-8731</u>		17. INFORMANT <u>Louise T. Duke</u> Address <u>Same as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary Occlusion</u>					<u>15 hours</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that (I) (this hospital) attended the deceased from <u>2-6</u> 19 <u>61</u> , to <u>2-6</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>2-6</u> 19 <u>61</u> , and that death occurred at <u>5 P.M.</u> , from the causes and on the date stated above					
22a. SIGNATURE <u>P. P. Andrews</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/6/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>P. P. ANDREWS M.D.</u>		22d. ADDRESS <u>4201 FESSENDEN ST. N.E. WASH. - D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/9/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Suitland, Maryland</u>		(State) _____			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Pough</u>		ADDRESS <u>Baltimore, Maryland</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 9 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02052

2075

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FALLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FALLAND NURSING Home		d. STREET ADDRESS 479-MAIN ST	
3. NAME OF DECEASED (Type or print) CLAUDIA Edmonston		4. DATE OF DEATH Feb-21 1961	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 20. 1877
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S	
13. FATHER'S NAME John P. Edmonston		14. MOTHER'S MAIDEN NAME FRANCES WHITWORTH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Address			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Accident 331X DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from March 14, 1960 to Feb-21, 1961 that (I) (we) last saw the deceased alive on Feb 20, 1961 , and that death occurred at 4:15 A.M. from the causes and on the date stated above					
22a. SIGNATURE Boris Rabkin		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED Feb 21, 1961	
22c. PHYSICIAN'S NAME (Type) BORIS RABKIN, M.D.		22d. ADDRESS 1818 University Boulevard East Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)		
Burial	2/23/61	St. Philip Cemetery Laurel, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE DeWitt Dunatchan Laurel Md.		ADDRESS		25a. REC'D BY REGISTRAR FEB 27 '61	25b. REGISTRAR'S SIGNATURE Arthur S. House

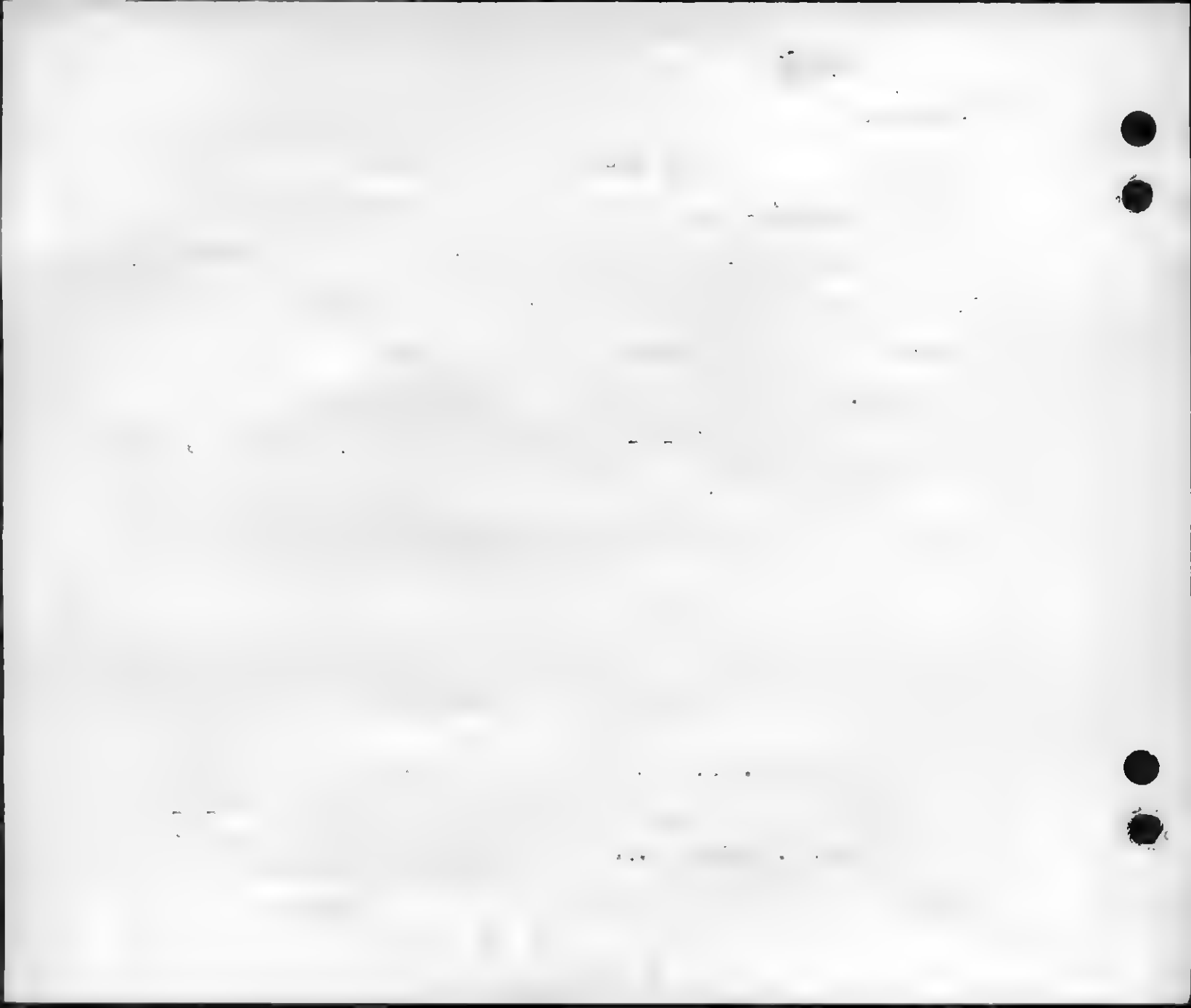
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



2076

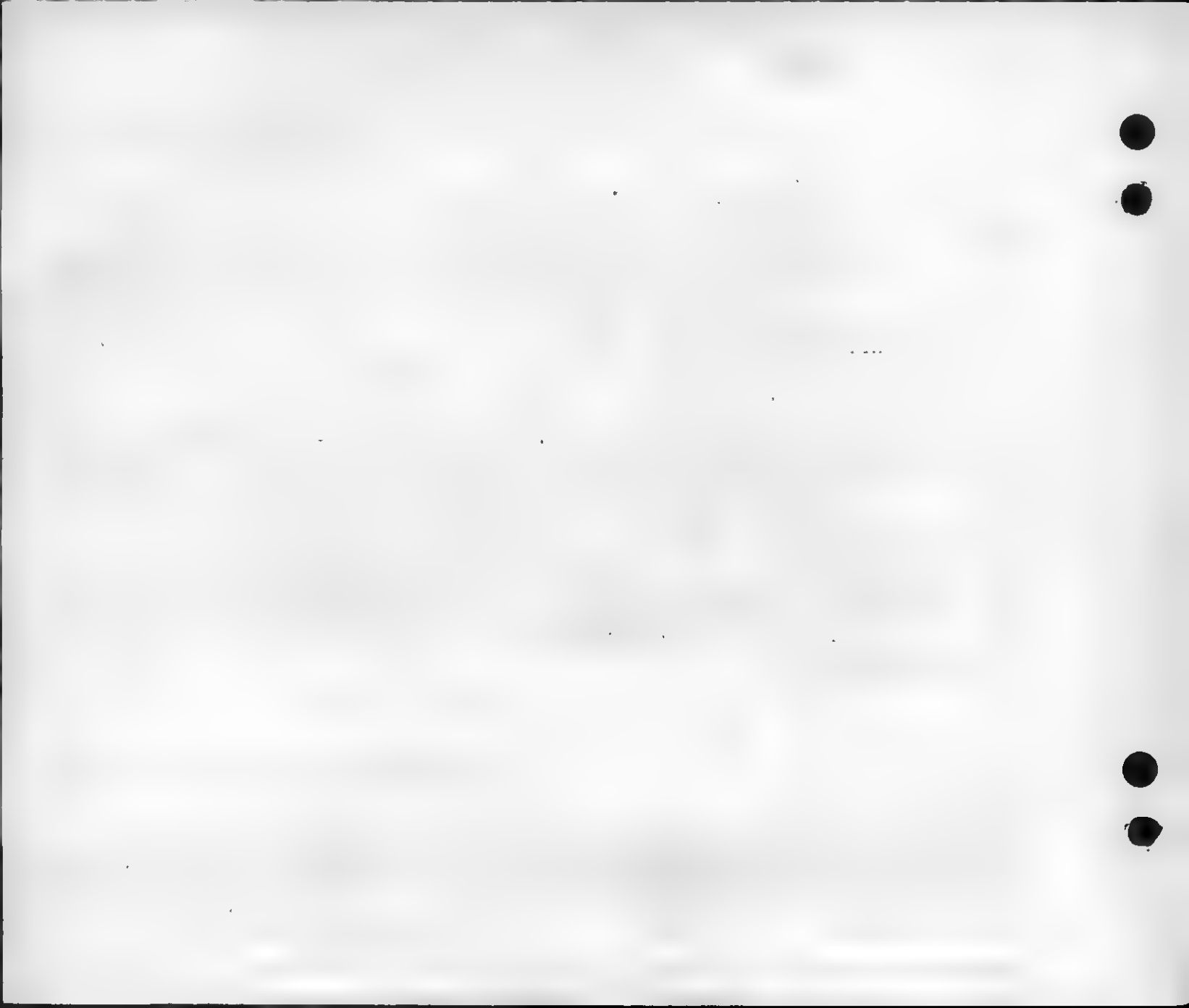
02053

MEDICAL CERTIFICATION



2077

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived) a. STATE <u>Maryland</u>		If institution- Residence before admission b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>4 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u>			
d. NAME OF HOSPITAL (If hospital, give street address) OR INSTITUTION <u>Havarest Nursing Home</u>		Blvd. East		d. STREET ADDRESS <u>8230 14th Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH</u>		First Middle Last <u>ENTWISLE</u>		4. DATE OF DEATH Month <u>February</u> Day <u>1</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>1/10/1862</u>		9 AGE (In years last birthday) <u>99</u> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired --- Dress Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Entwisle</u>		14. MOTHER'S MAIDEN NAME <u>Emily Stoutenburg</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>J. Douglas Pickens - 1519 Live Oak Drive Silver Spring, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>unknown</u> <u>unknown</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malnutrition</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/28</u> , 19 <u>60</u> , to <u>2/1</u> , 19 <u>61</u> ; that I last saw the deceased alive on <u>1/31</u> , 19 <u>61</u> , and that death occurred at <u>11:30</u> A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>918 University Blvd. E Silver Spring, Md.</u>		DATE SIGNED <u>2/1/61</u>			
ACTUAL SIGNATURE <u>Eino Magi</u>		M.D. <u>EINO MAGI</u>					
PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/4/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ivy Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Alexandria, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 3 '61</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2078

020557

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
c. LENGTH OF STAY IN 1b <u>8 hrs.</u>		d. STREET ADDRESS <u>6518 Flander Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Herman Nourse Esworthy</u>	4. DATE OF DEATH Month <u>February</u> Day <u>10</u> Year <u>1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-25-07</u>
9. AGE (in years last birthday) <u>54</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Member Crawford Co.</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>George Esworthy</u>	14. MOTHER'S MAIDEN NAME <u>Grace Curtis</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>Wife - Mrs. Helen Esworthy - same as above</u>		17. INFORMANT Address <u>same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>Myocarditis, toxic</u> DUE TO (b) <u>unknown</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>unknown</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Bronchopneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (i) (this hospital) attended the deceased from <u>Jan 24, 1961</u> , to <u>Feb. 10, 1961</u> , that (ii) (we) last saw the deceased alive on <u>Feb. 10, 1961</u> , and that death occurred at <u>9:25 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Eino Maci</u>		22b. DATE SIGNED <u>2/11/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>EINO MACI</u>		22d. ADDRESS <u>918 Blvd. E. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Feb. 10, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery, Prince Geo. Co.</u>	23d. LOCATION (City, town or country) (State) <u>Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Caesar Ct. NW. DC.</u>		25a. REC'D BY REGISTRAR <u>FEB 14 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

VR A15 (4)
15M 9/60



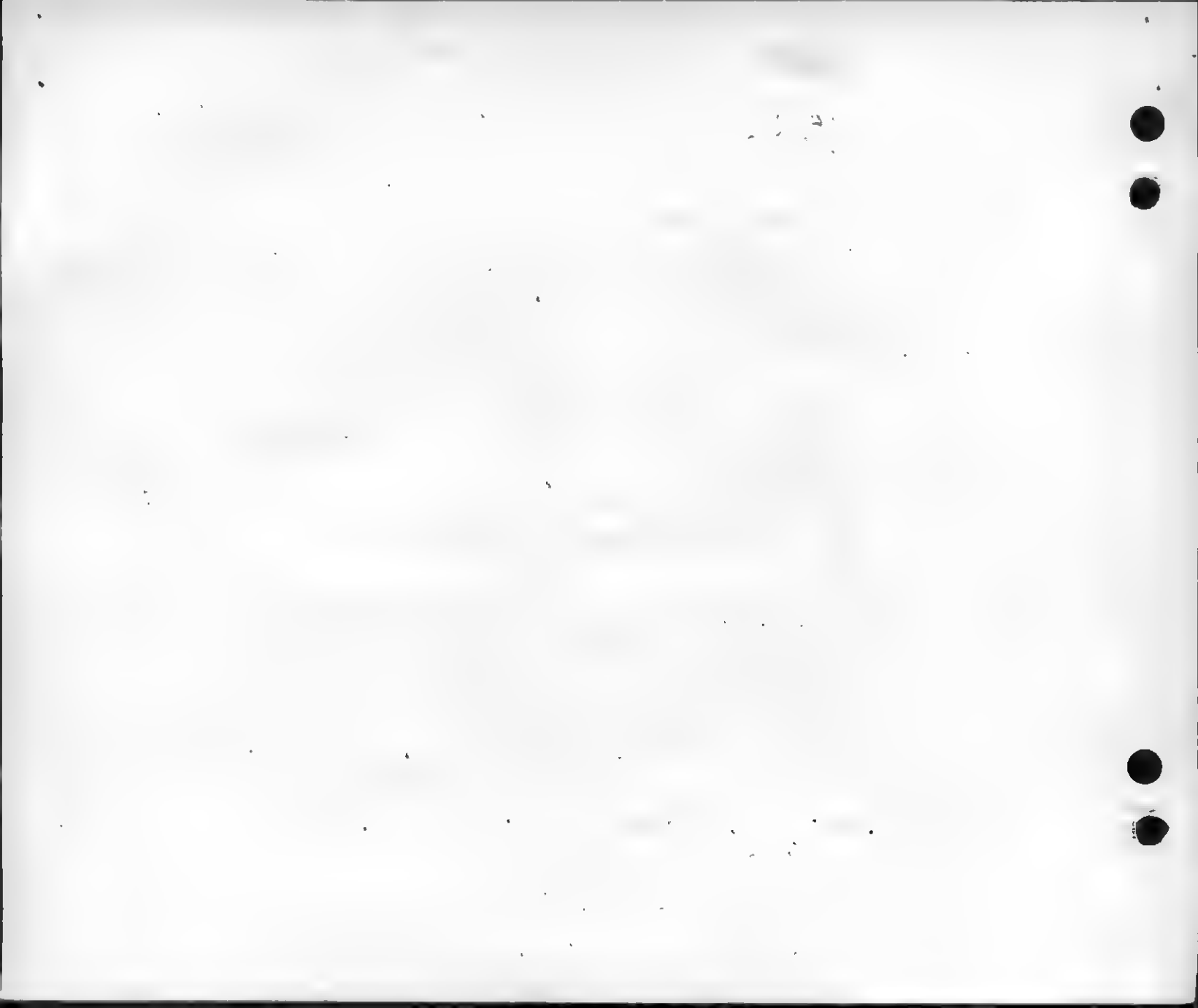
2079

CERTIFICATE OF DEATH

Reg. Dist. No. 02056

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>10 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		d. STREET ADDRESS <u>8513 BARRON ST.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8513 BARRON ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SAM</u> Middle <u>-</u> Last <u>FISCHER</u>				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>7</u> Year <u>1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 10, 1896</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ROUMANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BENJAMIN FISCHER</u>				14. MOTHER'S MAIDEN NAME <u>PAULINE ARONOWITZ</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>WIFE</u>		INFORMANT <u>8513 BARRON ST. TAKOMA</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> <u>153.8</u> DUE TO (b) <u>CARCINOMA OF COLCA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>DIABETES MELLITIS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUN 1, 1957</u> to <u>FEB 8, 1961</u> that I last saw the deceased alive on <u>FEB 6, 1961</u> and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Saul Zuckerman</u> M.D. <u>5410 Connecticut Ave</u>				DATE SIGNED <u>2-8-61</u>			
PHYSICIAN'S NAME (Type) <u>SAUL ZUCKERMAN, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-10-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BETH SHOLOM CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HILLSIDE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. DANZANSKY & SONS</u>				ADDRESS <u>3501-14 ST. NW</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 14 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

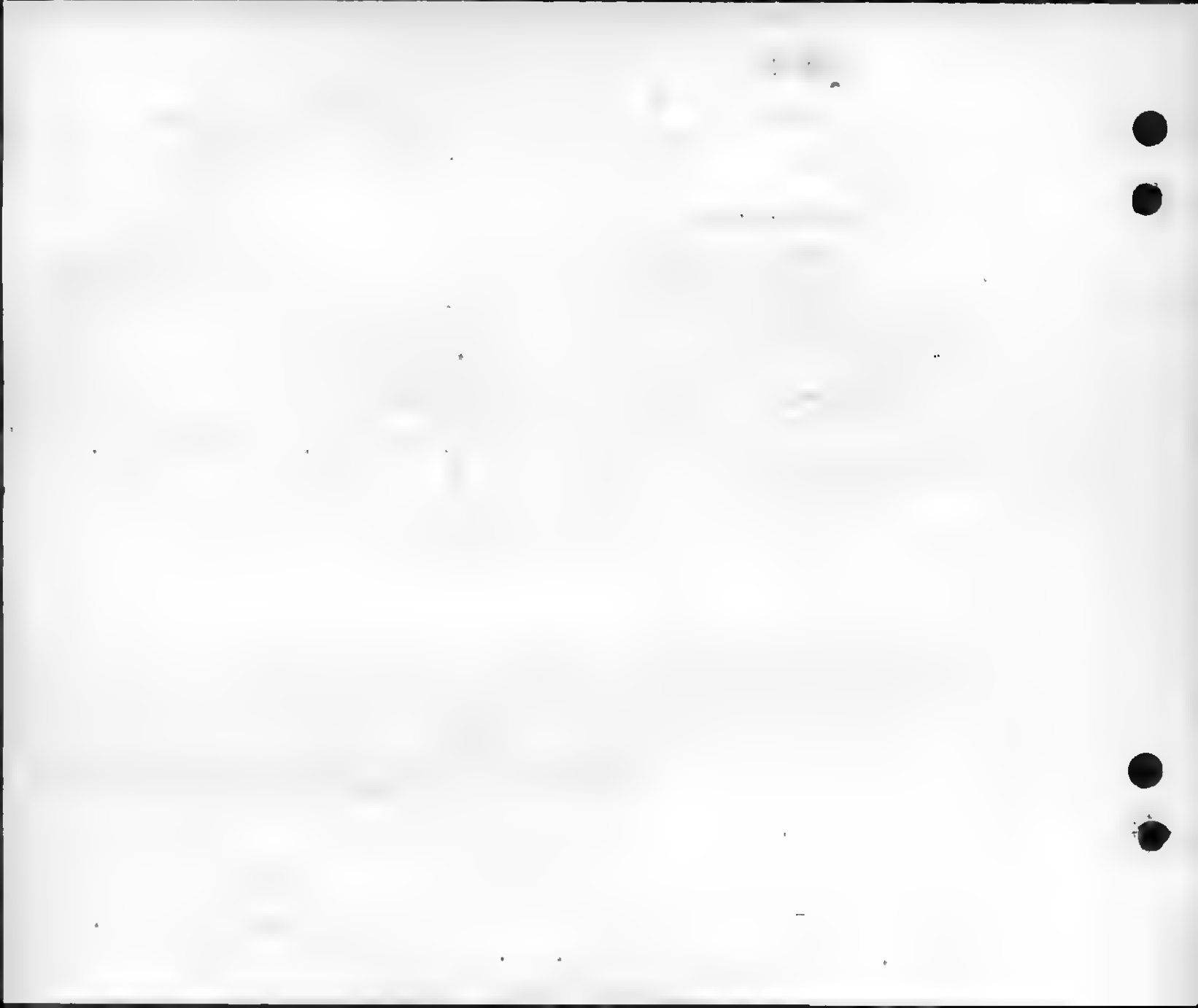
2080

CERTIFICATE OF DEATH

Reg. Dist. 42052

1. PLACE OF DEATH a. COUNTY Montg. MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown				c. LENGTH OF STAY IN 1b 2Yr 4Mo			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Marylander Home of Rest				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Marian Middle Fraily Last Fraily				4. DATE OF DEATH Month Feb Day 25 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 12-1872	
9. AGE (In years last birthday) 88 yrs		10. IF UNDER 1 YEAR Months 2 Days 13 Hours Min. 		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		INFORMANT Records. Montg. Co., Welfare Board.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia DUE TO Stroke, Rt. Hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Cerebral Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 6 days 60 days 4 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 59 , to 25 Feb , 19 61 , that I last saw the deceased alive on 23 Feb , 19 61 , and that death occurred at 7:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon Smith				ADDRESS (Street, city or town, state) Barnesville, Md. DATE SIGNED 25 Feb 61			
PHYSICIAN'S NAME (Type) Gordon Smith							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-1-61		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg. Md.				24a. REC'D BY REGISTRAR DATE MAR 2 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kears	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the attending physician and completely filled in by the funeral director, may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02058

2081

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase c. LENGTH OF STAY IN TB 4 years d. NAME OF HOSPITAL OR INSTITUTION, (if not in hospital, give street address) 4522 Dorset Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 4522 Dorset Avenue	
3. NAME OF DECEASED (Type or print) Anna L Freeman 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH July 26, 1888 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY ----- 11. BIRTHPLACE (County & State, or foreign country) Washington, D. C. 12. CITIZEN OF WHAT COUNTRY? USA		4. DATE OF DEATH February 11, 1961 9. AGE (in years last birthday) 72 yrs. F UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours M.n. 13. FATHER'S NAME Charles E. Poole 14. MOTHER'S MAIDEN NAME Laura Hays	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. Unknown 17. INFORMANT William E. Freeman - son - same 2d		18. CAUSE OF DEATH (Enter only one cause; use for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction 472 DUE TO Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/29/61 to 2/11/61 , that (I) (we) last saw the deceased alive on 2/10/61 , and that death occurred 2/11/61 from the causes and on the date stated above.			
22a. SIGNATURE E. Stuart Lyddane 22c. PHYSICIAN'S NAME (Type) E. Stuart Lyddane		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 2/11/61 22d. ADDRESS 3066 Q St. N. W., Wash. D. C.	
23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial 23b. DATE THEREOF 2/14/61		23c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery 23d. LOCATION (City, town or county) (State) Beallsville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR FEB 15 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

100



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

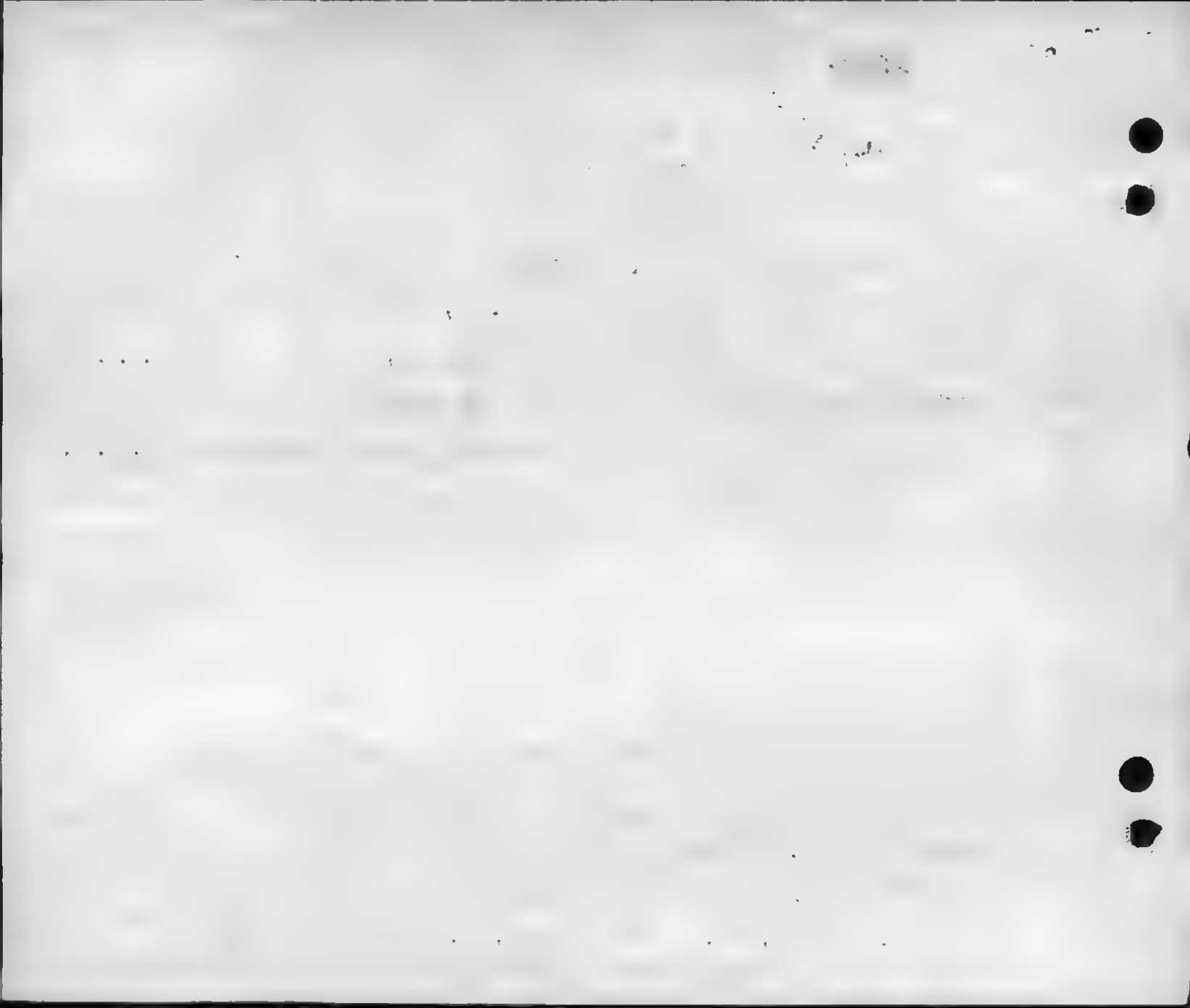
VS. A15ME
5M 7/59

MD
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2082 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02053

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 10 Months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 218 HILLSBORO DRIVE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 1320 E 33rd STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle C. Last Gleib		4. DATE OF DEATH Month FEB. Day 18 Year 19 61	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 12, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	9. AGE (In years last birthday) 80 yrs. IF UNDER 1 YEAR: Months 80 Days 0 Hours 0 Min. IF UNDER 24 HRS: Hours 0 Min. 0
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Martin Valentine Martin		14. MOTHER'S MAIDEN NAME Anna Martin Grieb	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs Bernard Simon		Address 218 Hillsboro Dr. S. S.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) Hypertension DUE TO (c) years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BROSCART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/21/61	
22c. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY		22d. LOCATION (City, town, or country) (State) BALTIMORE, MARYLAND	
23. FUNERAL DIRECTOR WARNER E. PUMPHREY, INC.		24a. REC'D BY REGISTRAR DATE FEB 23 '61	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	



TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician on completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

2083

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

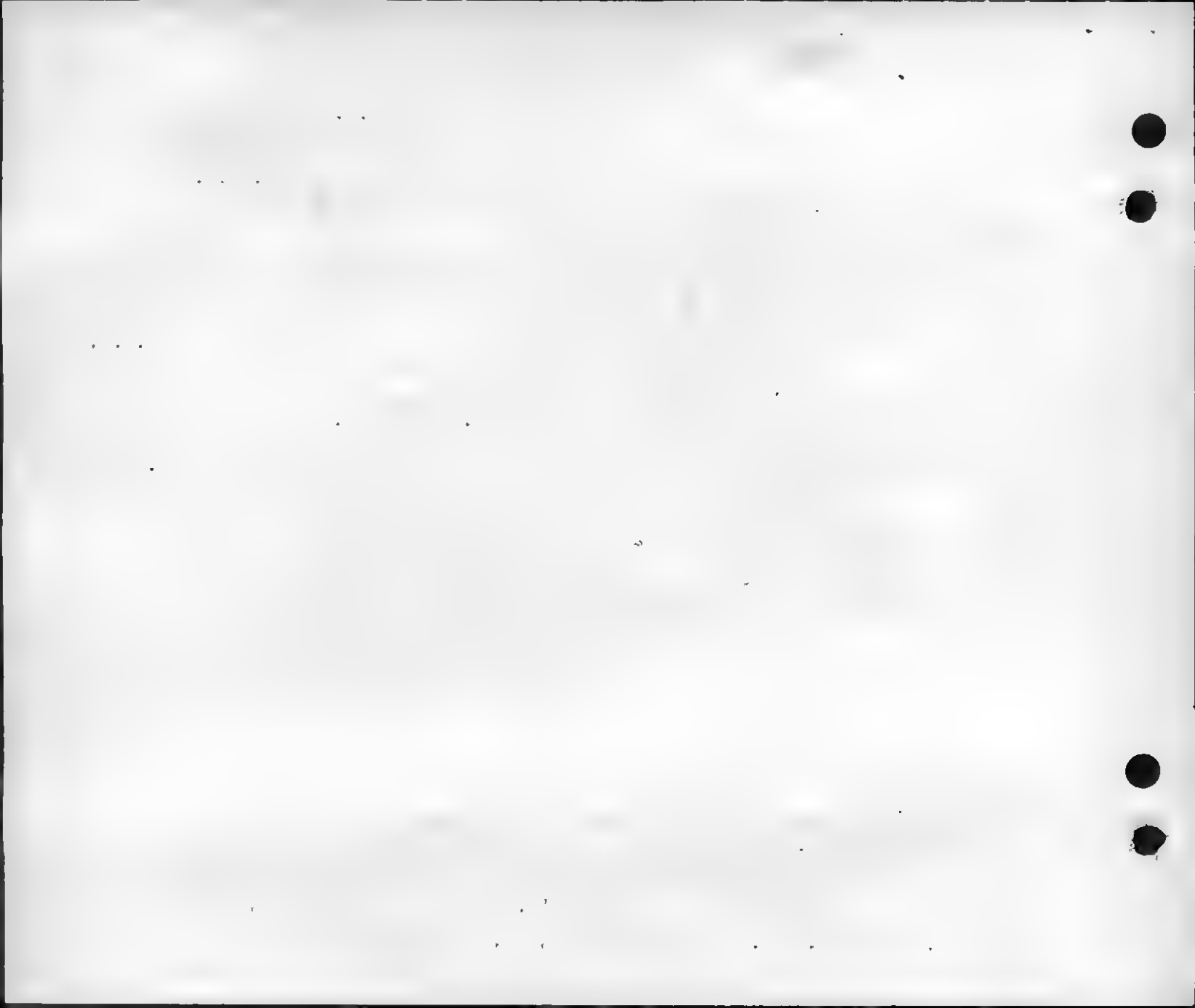
CERTIFICATE OF DEATH

02060

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> c. LENGTH OF STAY IN 1b <u>2 1/2 months</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wheaton Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>XXXX</u> D.C. b. COUNTY <u>XXXXXX</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> d. STREET ADDRESS <u>2702 17th St., N.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Mary</u> Last <u>Goldman</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1877</u> <u>May - 1 - 1877</u> AGE (in years last birthday) <u>83</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Richmond, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Chase</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>Dr. Orville M. Goldman, son</u> <u>105 Northbrook Lane</u> <u>Bethesda, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> (b) <u>Myocardial Infarction</u> (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 yrs</u> (b) <u>1 mo</u> (c) <u>1 mo</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 3</u> <u>1961</u> , to <u>Feb 18</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>Feb 16</u> <u>1961</u> , and that death occurred on <u>Feb 18</u> <u>1961</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>James M. Whitlock MD</u>		22b. DATE SIGNED <u>2-18-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES M. WHITLOCK</u>		22d. ADDRESS <u>2702 Carroll Ave., Takoma Park, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/21/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WALTER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>		25a. REC'D BY REGISTRAR <u>FEB 23 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Clifford A. Hines</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Dr. Brochert was contacted item 3 Film 432 3-3-61 et

1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN b. 2 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
a. STATE Maryland
b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville
d. STREET ADDRESS 1307 Patton Place

3. NAME OF DECEASED (Type or print)
First Robert Middle Albert Last Coronano

4. DATE OF DEATH
Month February Day 24 Year 1961

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 5-25-97
WIDOWED ☐ DIVORCED ☐ 9. AGE (In years last birthday) 63 yrs. IF UNDER 1 YEAR: Months 6 Days 13 IF UNDER 24 HRS.: Hours 13 Min. 00

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant 10b. KIND OF BUSINESS OR INDUSTRY Construction Co. 11. BIRTHPLACE (County & State, or foreign country) Italy 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Christopher Coronano 14. MOTHER'S M.A.D.N. NAME Romano

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes WW I 16. SOCIAL SECURITY NO. MISS MARGARET CORONANO - 705 18th St. N.W. 17. INFORMANT Daughter Address MISS MARGARET CORONANO - 705 18th St. N.W.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Aneurysm, Ascending Aorta, Dissecting DUE TO CARDIAC TAMPONADE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3 HRS (c) 3 HRS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (e); 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 FEB 24, 1961 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from FEB 24, 1961 to FEB 24, 1961, that (I) (was) last saw the deceased alive on FEB 24, 1961, and that death occurred at 11:25 A.M. from the causes and on the date stated above.

22a. SIGNATURE Edward A. Beeman M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED FEB 24, 1961

22c. PHYSICIAN'S NAME (Type) EDWARD A. BEEMAN 22d. ADDRESS 10620 GEORGIA AVE, SILVER SPRING, MD

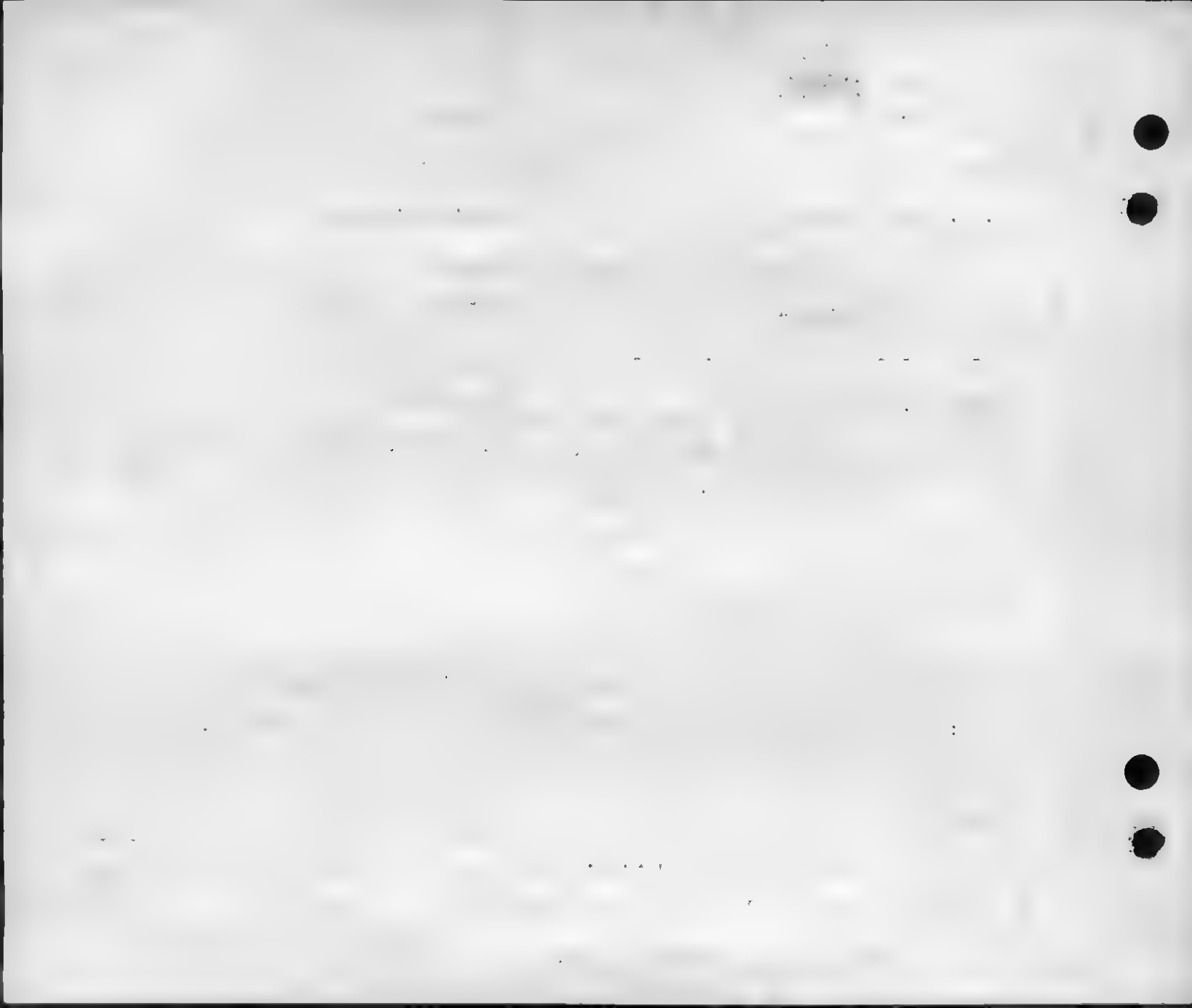
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE Spencer Wheeler ADDRESS 1331 E. Montgomery Ave. Rockville Md 25a. REC'D BY REGISTRAR DATE FEB 27 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





02063

2086

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
TSM 9/5/91



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2087

02064

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY (In days) 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, if inst'l on: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS 10108 Pierce Drive

3. NAME OF DECEASED (Type or print) Fannie SCHUM
First Middle Last
Fannie SCHUM Hannum

4. DATE OF DEATH February 10 1961
Month Day Year

5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH April 20, 1882
yrs. Months Days Hours Min.

9. AGE (In years, if under 1 year, last birthday) 78
yrs. Months Days Hours Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 11. BIRTHPLACE (County & State, or foreign country) Pennsylvania
own home

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Frank Schum 14. MOTHER'S MAIDEN NAME Fannie Womer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no 16. SOCIAL SECURITY NO. none 17. INFORMANT Washington Sanitarium and Hospital Records
Address 7600 Carroll Ave Takoma Park

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b) Coronary sclerosis
(c) Due to
(e), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (e) Congestive heart failure

19. WAS AN AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Feb 2 1961 20d. INJURY OCCURRED At work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) At work 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb 2 1961 to Feb 10 1961, that (I) (we) last saw the deceased alive on Feb 9 1961, and that death occurred at 4:45 M, from the causes and on the date stated above.

22a. SIGNATURE A. F. Thibadeau 22b. DATE SIGNED 2/10/61
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22d. ADDRESS 10111 Colesville Rd. SILVER SPRING MD.

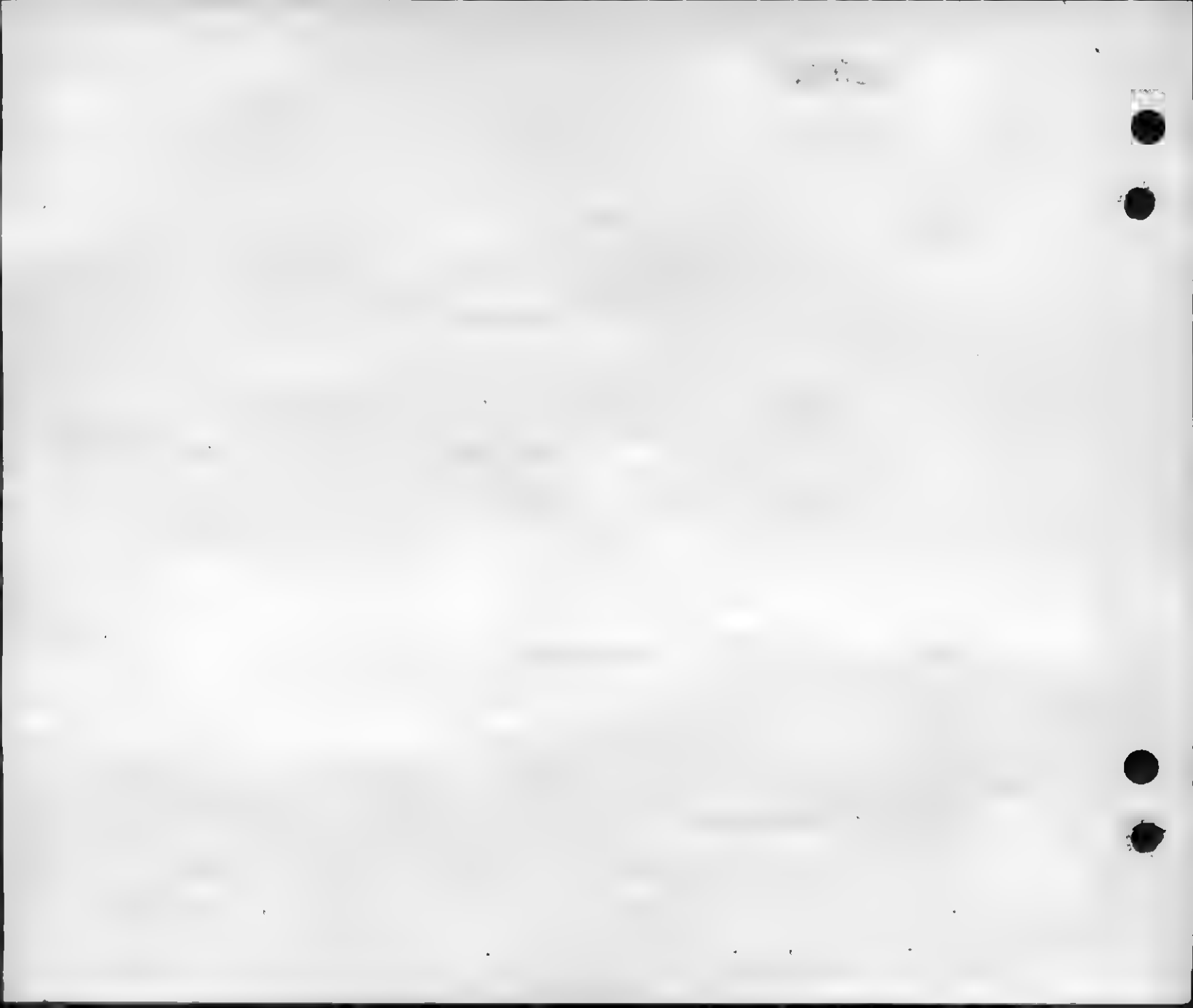
23a. BURIAL, CREMATION, or REMOVAL (Specify) BURIAL 23b. DATE THEREOF 2/13/61 23c. NAME OF CEMETERY OR CREMATORY HOMEWOOD CEMETERY 23d. LOCATION (City, town or county) (State) PITTSBURG, PENNSYLVANIA

24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska ADDRESS SILVER SPRING, MD. 25a. REC'D BY REGISTRAR FEB 14 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Thorne

TO HOSPITAL: The law requires that the death certificate be executed after death. The attending physician, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, removal, and in any event, within 72 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, removal, and in any event, within 72 hours of death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2088

CERTIFICATE OF DEATH

02065

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Derwood</u>			
c. LENGTH OF STAY IN 1b <u>Suburban Hospital</u>				d. STREET ADDRESS <u>Derwood</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Archibald Leonard Harris</u>		4. DATE OF DEATH Month Day Year <u>February 28 1961</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 6, 1893</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. <u>68 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>A. HARRIS</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca E. Galeano</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>7315 Lacona St. S.E. Washington, D.C.</u>		17. INFORMANT <u>Wordna Galeano</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pelvic Abscess And Peritonitis</u> DUE TO (b) <u>Separation of uretero-sigmoid Anastomosis</u> DUE TO (c) <u>Total Cystectomy For Malignancy</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. TIME OF INJURY Hour a.m. p.m. <u>19</u>		21. I certify that (I) (this hospital) attended the deceased from <u>Feb 5 - 1961</u> , to <u>2-27-1961</u> , that (I) (we) last saw the deceased alive on <u>2-27-1961</u> , and that death occurred at <u>7:55 AM</u> , from the causes and on the date stated above.		22. SIGNATURE <u>Linwood H. Johnson Jr.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-2-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u>		23d. LOCATION (City, town or county) (State) <u>Rockville Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Hanna</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 2 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>		26. ADDRESS <u>316 E. Diamond Ave., Baltimore, Md.</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed in 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1750



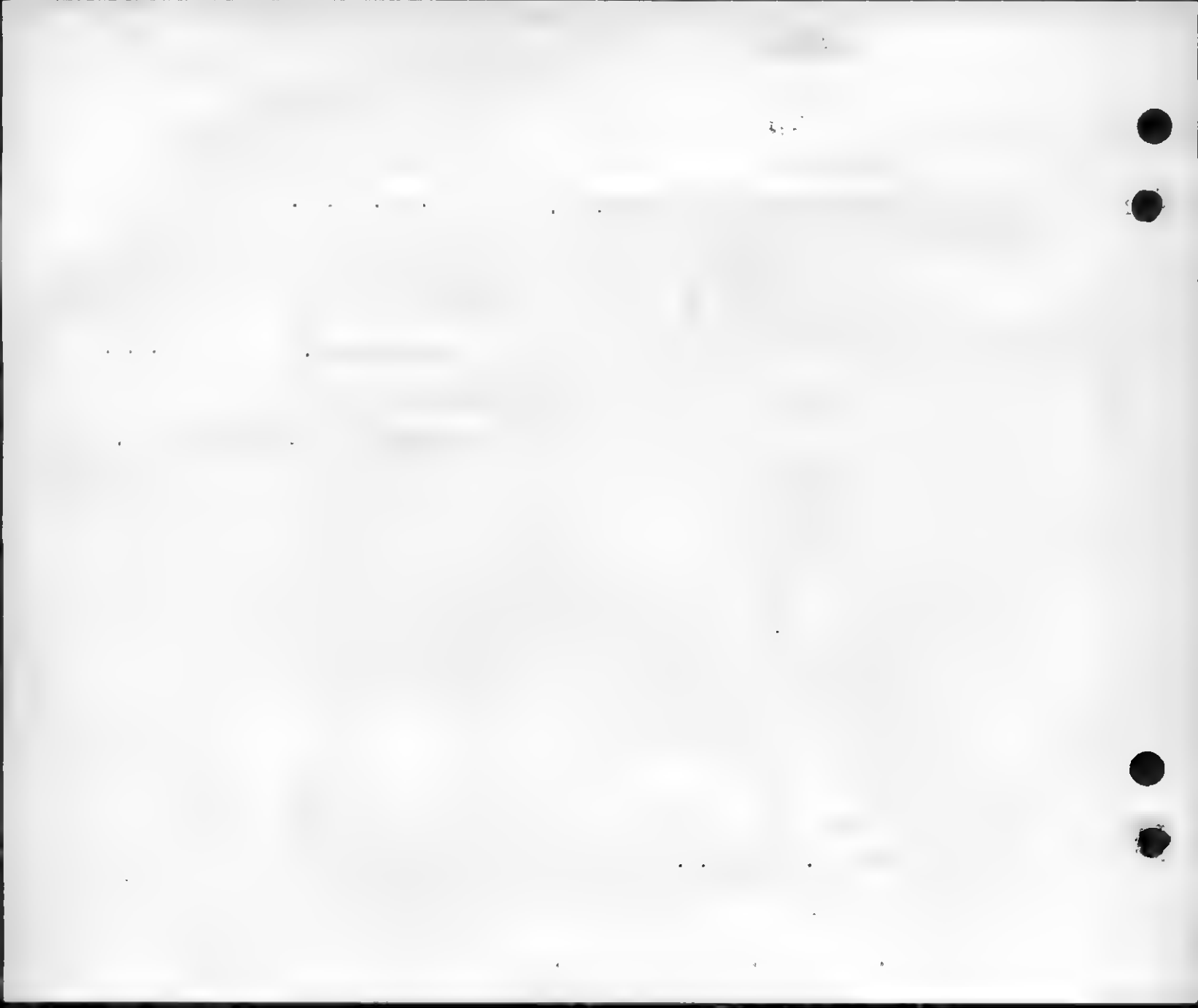
1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2089
CERTIFICATE OF DEATH

02066

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home for the Aged, Inc.		d. STREET ADDRESS 916 K. St., N. E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ida Middle Belle Last Harvey		4. DATE OF DEATH Month 2 Day 2 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 6, 1880
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR: Months 81 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Millgreen, Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Bailey Biles		14. MOTHER'S MAIDEN NAME Helen Jane Pyle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Asbury Home records - Gaithersburg, Md.		Address Asbury Home records - Gaithersburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Generalized Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive Cardiovascular Disease DUE TO (c) Hypertensive Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH Years.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardiovascular Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct , 19 60 , to Feb 2 , 19 61 , that I last saw the deceased alive on Jan 26 , 19 61 , and that death occurred at 9:20 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 7720 Wisconsin Ave. DATE SIGNED Bethesda Md.	
ACTUAL SIGNATURE James W. Egan		MD 7720 Wisconsin Ave.	
PHYSICIAN'S NAME (Type) James W. Egan, M.D.		Bethesda Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-4-61	
22c. NAME OF CEMETERY OR CREMATORY Emory Church Cemetery		22d. LOCATION (City, town, or county) (State) Street. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner, Gaithersburg, Md.		24a. REC'D BY REGISTRAR FEB 6 '61 24b. REGISTRAR'S SIGNATURE Arthur L. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be released by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

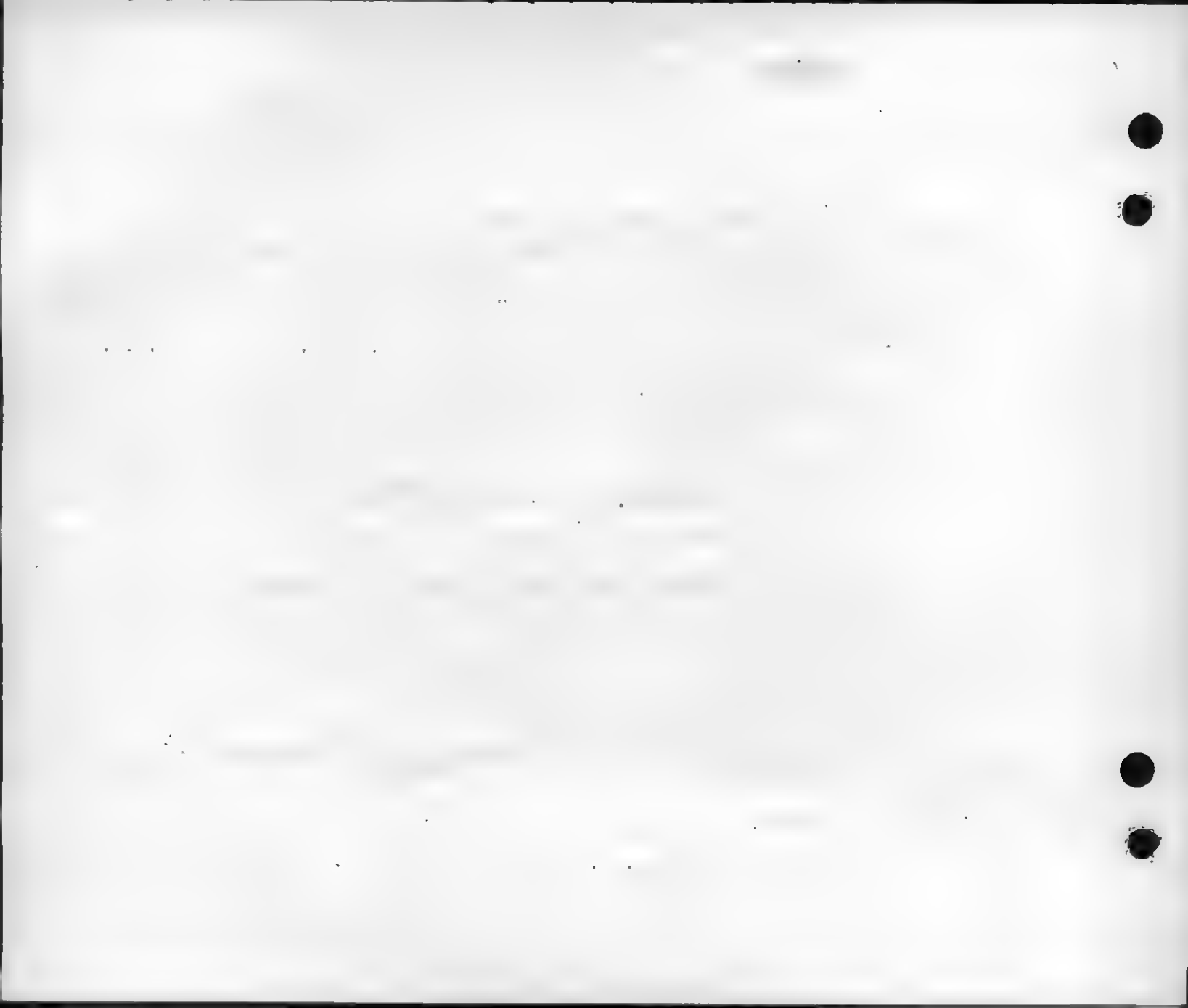
VR A15 (4)
15M 9/59

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2090

02067

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 32 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				d. STREET ADDRESS 16 WILLIAM STREET			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First RUFUS Middle KING Last HELPHENSTINE JR				4. DATE OF DEATH Month FEBRUARY Day 17 Year 19 61			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-25-1882	
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.		11. IF UNDER 24 HRS Hours <input type="checkbox"/> Min.			
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) FORRESTER				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME RUFUS KING HELPHENSTINE				14. MOTHER'S MAIDEN NAME LAURA PLANT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 217-26 8616		17. INFORMANT Address HOSPITAL RECORDS, OLNEY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL METASTASIS 162-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) CHRONIC RENAL FAILURE DUE TO (c) BROCHOCARCINOMA				INTERVAL BETWEEN ONSET AND DEATH SIX MONTHS ONE MONTH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from JANUARY 10 1961 to FEBRUARY 17 1961 , that (I) (we) last saw the deceased alive on FEBRUARY 16 1961 , and that death occurred at 9:20 A.M. from the causes and on the date stated above.							
22a. SIGNATURE G. S. ROSENBERGER, M. D.				22b. DATE SIGNED FEB 17, 1961		22c. ADDRESS ROCKVILLE, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF 2/2/61		23c. NAME OF CEMETERY OR CREMATORY GREENWOOD	
23d. LOCATION (City, town, or county) (State) ROCKVILLE, D.C.							
24. FUNERAL DIRECTOR'S SIGNATURE Funeral Home				25a. REC'D BY REGISTRAR DATE FEB 20 '61		25b. REGISTRAR'S SIGNATURE Arthur S. House	



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed in 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 may be retained by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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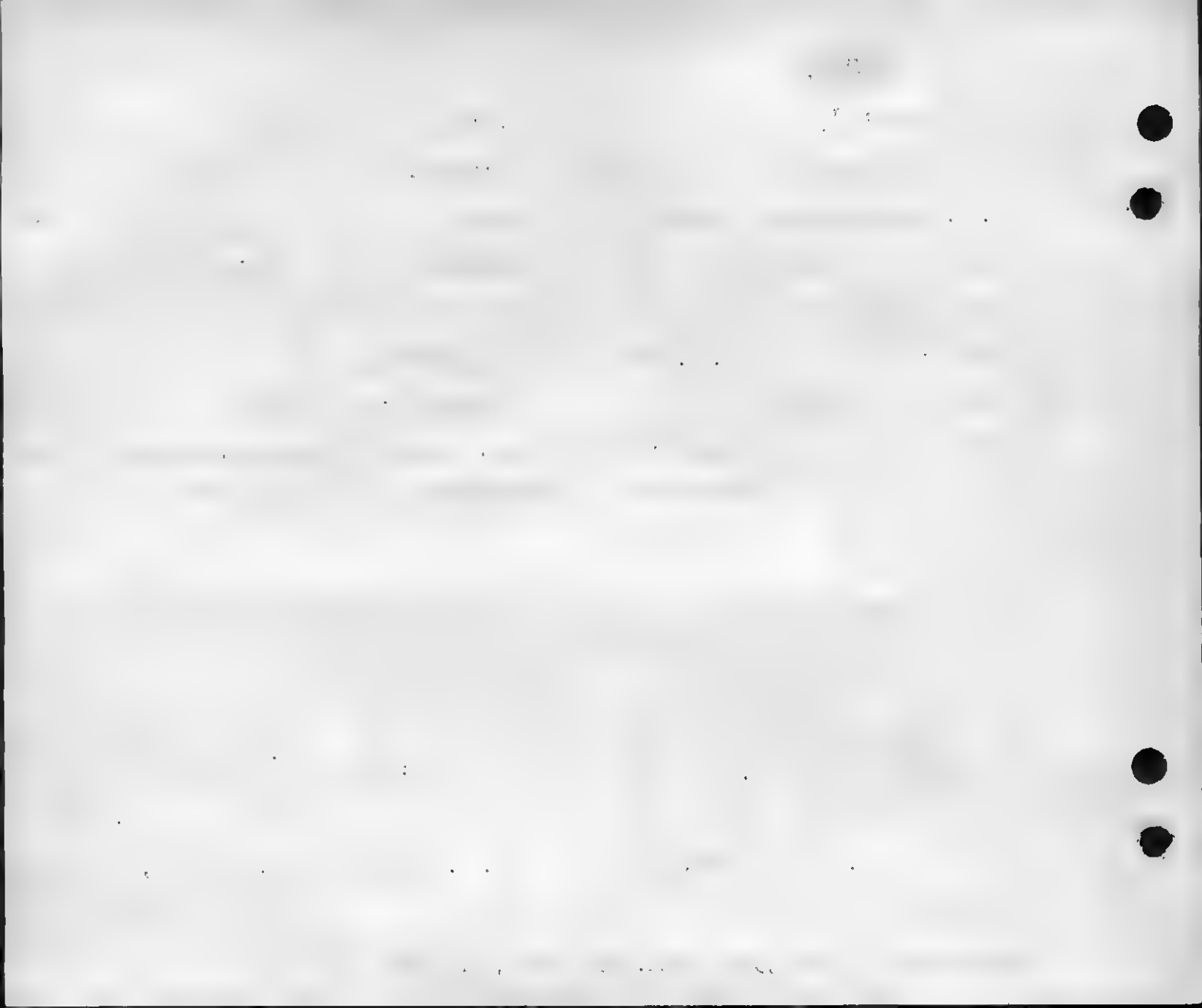
MEDICAL CERTIFICATION

2091

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02068

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN b 51 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Arrington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arrington d. STREET ADDRESS RFD	
3. NAME OF DECEASED (Type or print) Russell First Massie Middle HENDERSON Last		4. DATE OF DEATH Month February Day 17 Year 19 61	
5. SEX Male 6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		9. AGE (In years last birthday) 26 yrs.	
10. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (County & State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Elmo Ward HENDERSON	
14. MOTHER'S MAIDEN NAME Virginia Lucille SAUNDERS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes	
16. SOCIAL SECURITY NO. 231-38-0860		17. INFORMANT (W) Mrs. Juanita W. Henderson, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, EMBRYONAL, WITH METASTASES 199.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from Dec. 28, 1960, to Feb. 17, 1961 that (we) last saw the deceased alive on Feb. 17, 1961 , and that death occurred at 4:25 AM , from the causes and on the date stated above.			
22a. SIGNATURE H. Hubbard 22c. PHYSICIAN'S NAME (Type) H. HUBBARD, CDR, MC, USN 22b. DATE SIGNED 2-17-61 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2-19-61 23c. NAME OF CEMETERY OR CREMATORY Family Cemetery 23d. LOCATION (City, town or county) (State) Piney River Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE John W. Demaines 25a. REC'D BY REGISTRAR Feb 20 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hume			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

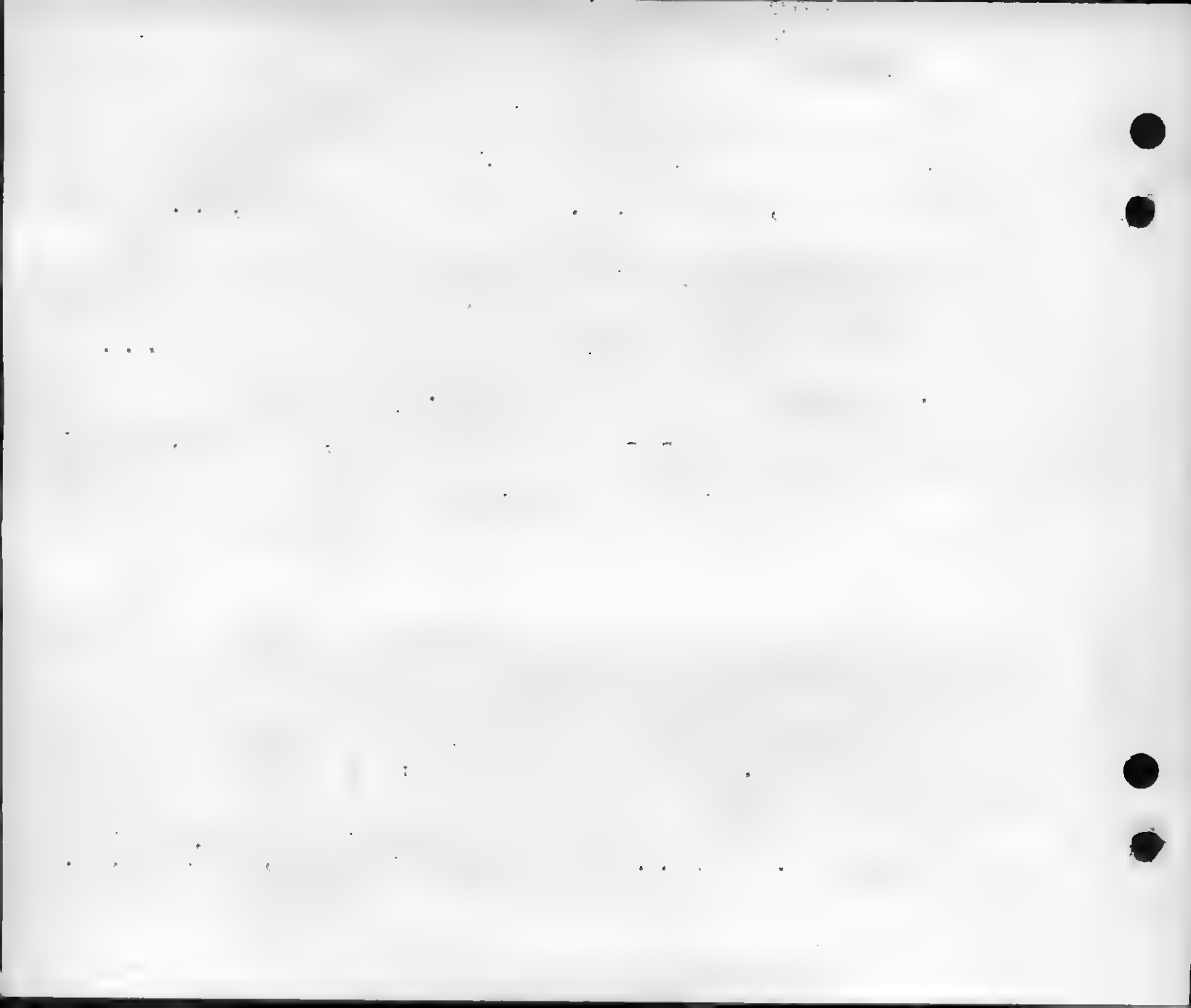
2092

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

0206.1

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 165 days		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE District of Columbia		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 3040 Massachusetts Avenue, S.E.					
3. NAME OF (Type or print) William Anthony Henderson		First Middle Last		4. DATE OF DEATH February 10 19 61		Month Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 7, 1891		9. AGE (in years last birthday) 69 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship Wright		10b. KIND OF BUSINESS OR INDUSTRY Ship building		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John W. Henderson		14. MOTHER'S MAIDEN NAME Anna E. Rice							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-24-7183		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Necrotizing pneumonia, left lower lobe DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple myeloma DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 days 3 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from August 29, 1960 , to February 10, 1961 , that (I) (we) last saw the deceased alive on Feb. 10, 1961 , and that death occurred at 1:25 AM on the causes and on the date stated above.									
22a. SIGNATURE Martin J. Cline		M. D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/11/61			
22c. PHYSICIAN'S NAME (Type) MARTIN J. CLINE, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.							
23a. BURIAL CREMATION, REMOVAL (Specify) 2/13/61		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Edgar Hill		23d. LOCATION (City, town, or county) (State) Suitland, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE R. G. Mattingly		ADDRESS 131-11th St. S.E.		25a. REC'D BY REGISTRAR Feb 14 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hunt			



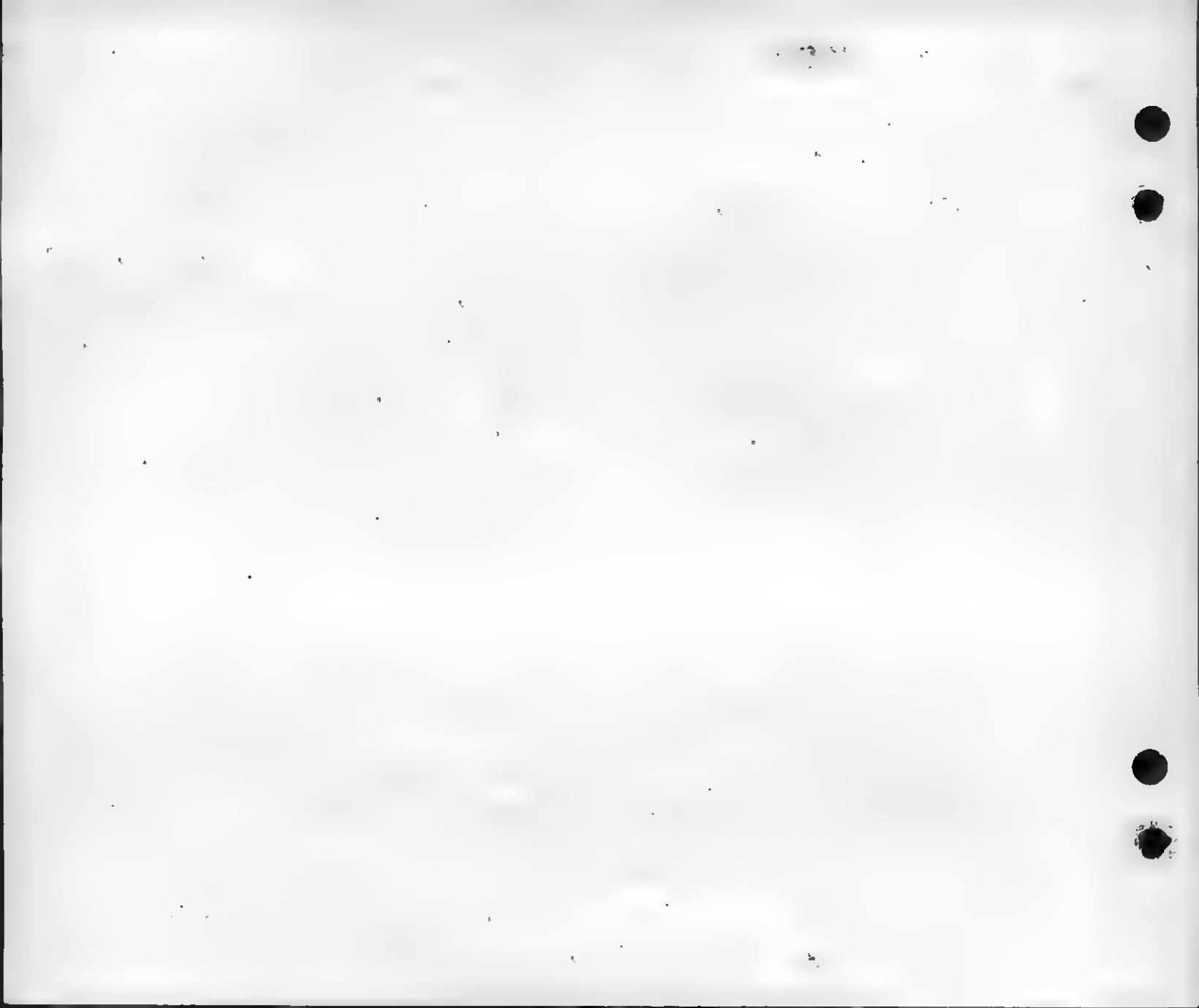
2093

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02070

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3913 Hamden Street.				d. STREET ADDRESS 3913 Hamden		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CORA Middle ALICE Last HICINS				4. DATE OF DEATH Month Feb. Day 25 Year 1961			
5. SEX female		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 7, 1865	
9. AGE (In years last birthday) 95		IF UNDER 1 YEAR Months 2 Days 18		IF UNDER 24 HRS Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) 1 Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME George Spinner				14. MOTHER'S MAIDEN NAME Mary J. (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 				16. SOCIAL SECURITY NO 		17. INFORMANT Mrs. Lillie Cohen Address 3913 Hamden St., Kensington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Chronic Myo Carditis (Senile) 1952(P)							
(b) Chronic Intestinal Nephritis 1955P							
(c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a))							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 							
20c. TIME OF INJURY Month Day 19 Year Hour a. m. p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	
20f. (City or town) 				20g. (County) 		20h. (State) 	
21. I certify that (I) (this hospital) attended the deceased from June 1954 to Feb 25, 1961 , that (I) (was) last saw the deceased alive on 2-24-1961 and that death occurred at 2 PM , from the causes and on the date stated above.							
22a. SIGNATURE Calvin B. LeCompte				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/25/61	
22c. PHYSICIAN'S NAME (Type) Calvin B. LeCompte				22d. ADDRESS 61 R. St. NE Wash DC			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/25/61		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial.		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville, Md.		25a. REGISTRAR'S SIGNATURE Arthur S. Hume	
25b. REGISTRAR'S SIGNATURE 				25c. REGISTRAR'S SIGNATURE 		25d. REGISTRAR'S SIGNATURE 	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The attending physician or funeral director must sign this certificate. The law requires that the death certificate be executed within 24 hours after death. The attending physician or funeral director must sign this certificate. The law requires that the death certificate be executed within 24 hours after death. The attending physician or funeral director must sign this certificate.



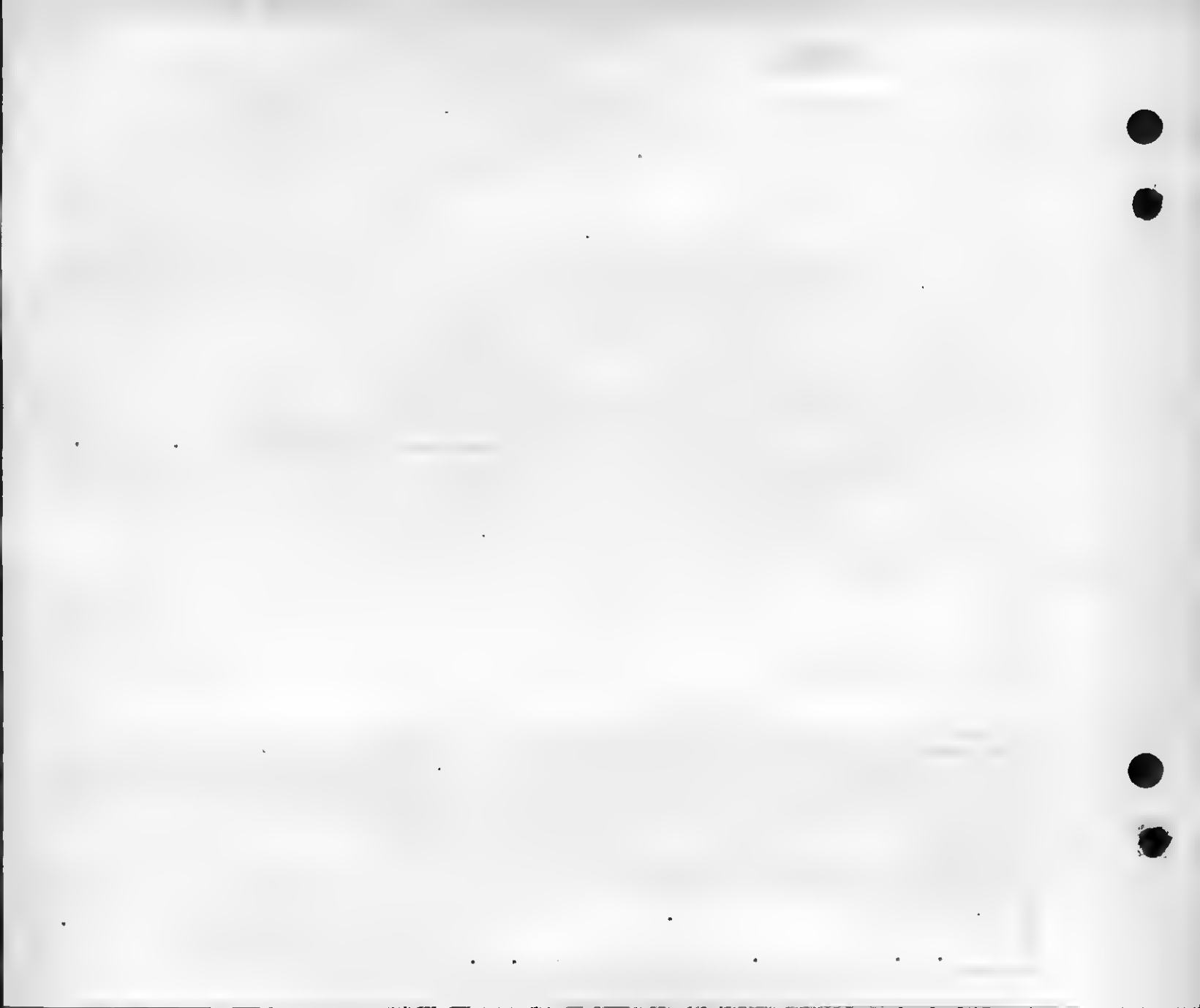
2094

CERTIFICATE OF DEATH

Reg. Dist. No. 02071

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) 5902 Sonoma Road		d. STREET ADDRESS 5902 Sonoma Road	
3. NAME OF DECEASED (Type or print) First Gizela Middle Hild Last Hild		4. DATE OF DEATH Month February Day 20 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/14/1876
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Roumania		12. CITIZEN OF WHAT COUNTRY? Roumania	
13. FATHER'S NAME Ludwig Hesshaimer		14. MOTHER'S MAIDEN NAME Julia Lassel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Charles Hild		Address Bethesda Md.	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 DUE TO Respiratory Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Thrombosis (c) Generalized Hypertension & Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 2 days 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/7 , 19 60 , to 2/20 , 19 61 , that I last saw the deceased alive on 2/18 , 19 61 , and that death occurred at 8:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4301 48th St. NW Washington D.C. DATE SIGNED			
ACTUAL SIGNATURE S. A. Thomas M.D.		PHYSICIAN'S NAME (Type) S. A. Thomas M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation 2/20/61		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.		24a. REC'D BY REGISTRAR FEB 21 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.



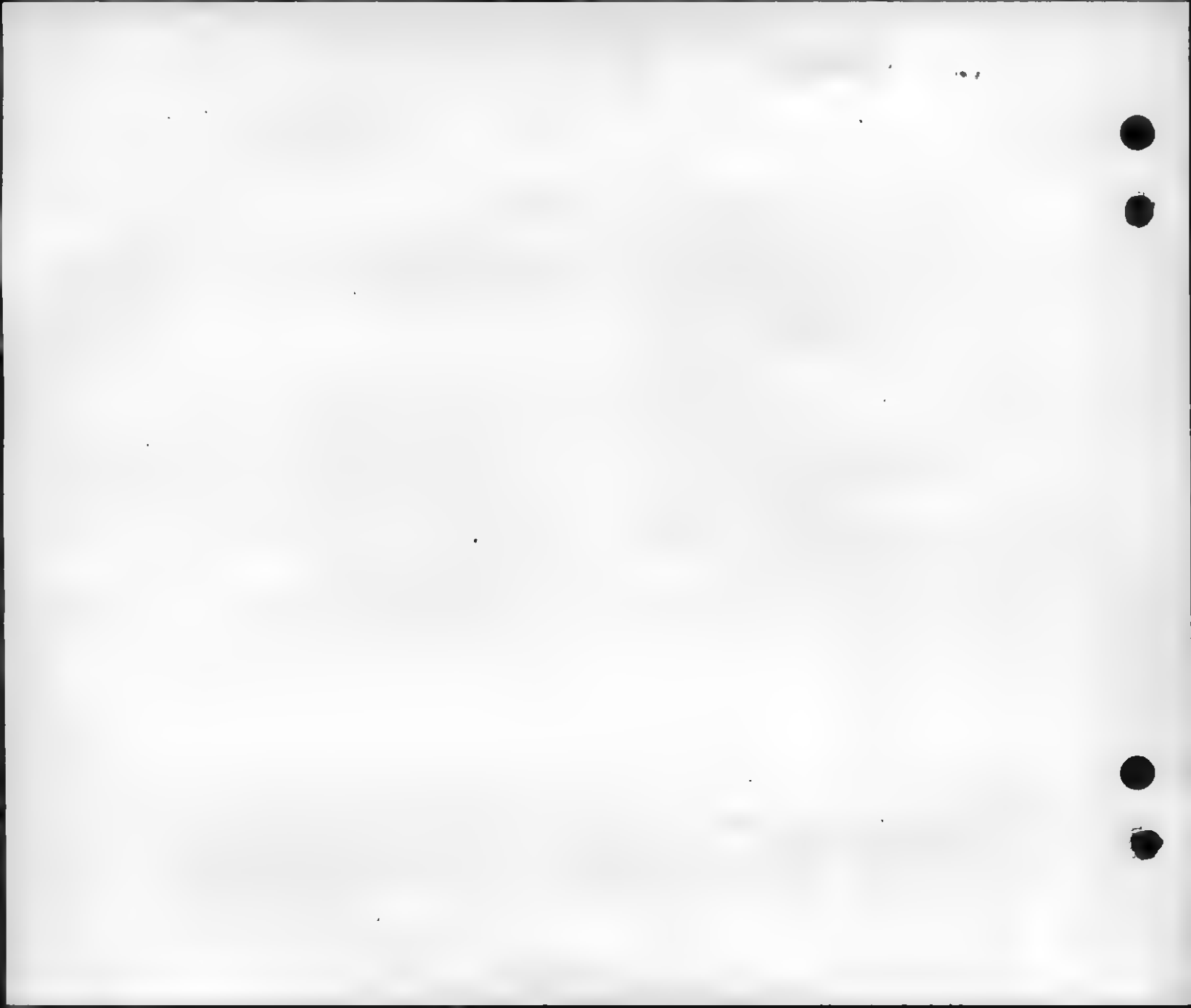
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

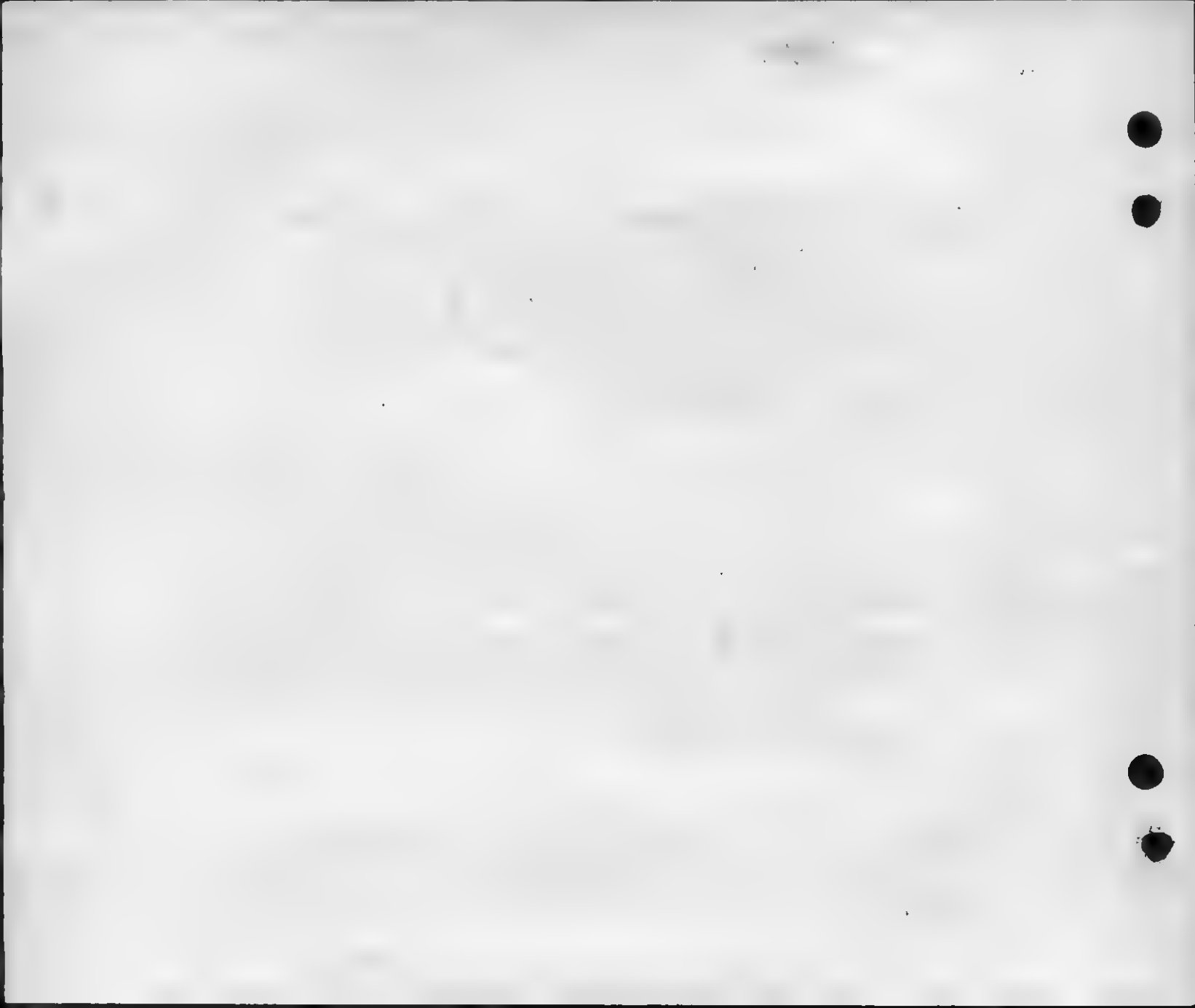
2095

02072

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> LENGTH OF STAY IN 1b <u>4</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wheaton Nursing Home</u>				d. STREET ADDRESS <u>110906-Oakwood St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Leon</u> Middle <u>N</u> Last <u>Hirschman</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>6</u> Year <u>1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 14, 1885</u>	
9 AGE (In years last birthday) <u>75</u> yrs		IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u>		IF UNDER 24 HRS Hours <u>15</u> Min <u>5</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Behr Hirschman</u>				14. MOTHER'S MAIDEN NAME <u>Blume</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>Behr Hirschman 10906-Oakwood St. Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420 Congestive Heart Failure</u> DUE TO (b) <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>Gen. Arteriosclerosis</u> DUE TO (c) <u>Gen. Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u> <u>3 yrs</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>Feb 2, 1961</u> to <u>Feb 6, 1961</u> that (1) (last) saw the deceased alive on <u>Feb 6, 1961</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Armand B. Gordon</u> M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED <u>2/6/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Armand B. Gordon, M.D.</u>				22d. ADDRESS <u>2828 Conn. Ave. N.W., Wash. D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>FEB 8, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE HEBREW</u>		23d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Sol. Levinson & Bros. Inc. 6010 Reist Road</u>				25a. RECEIVED BY REGISTRAR DATE <u>FEB 14 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be used by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

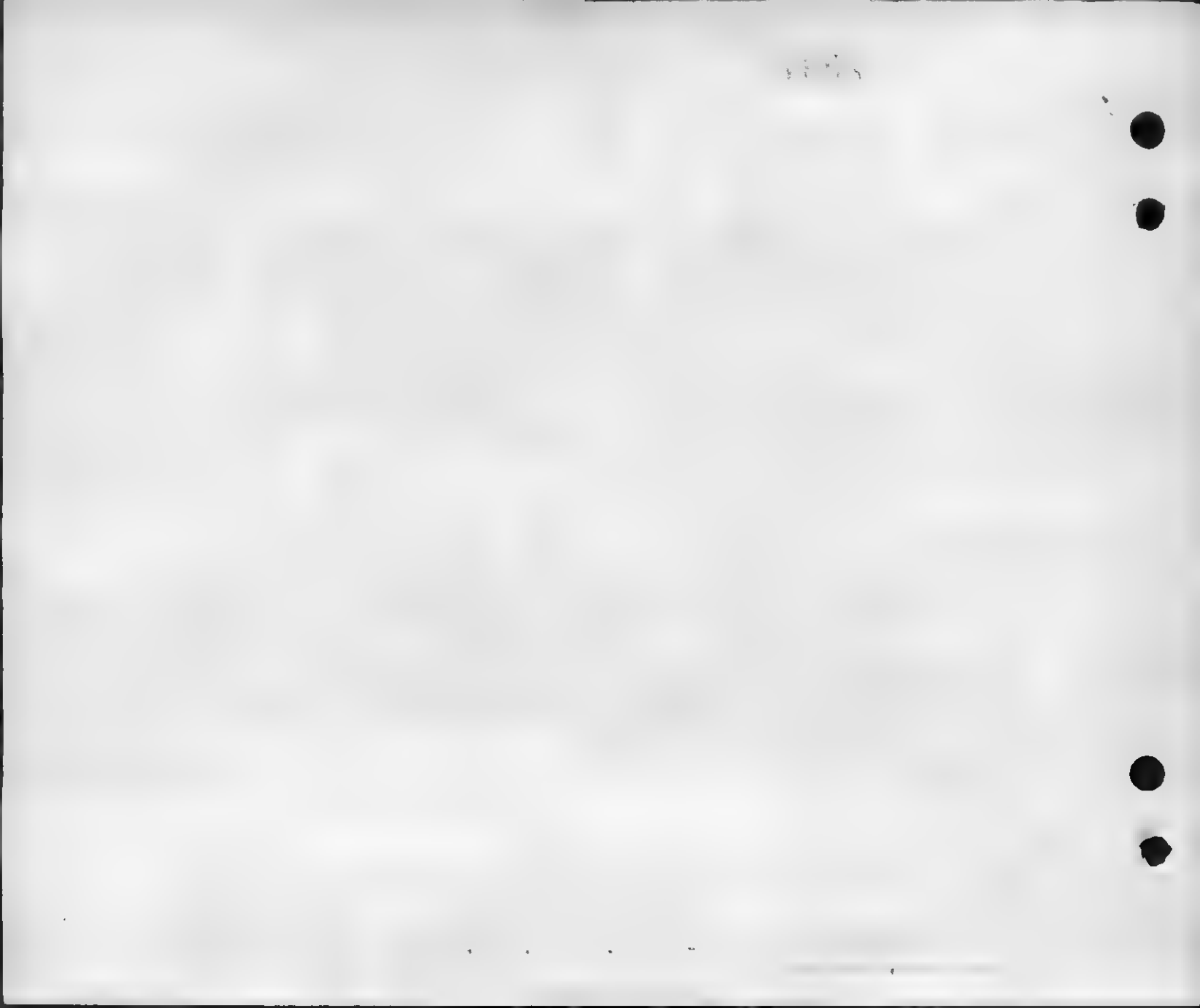
2097

CERTIFICATE OF DEATH

02074

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>13 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GermanTown</u> d. STREET ADDRESS <u>Route 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Baby Girl HITT</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>26</u> Year <u>1961</u>		5. SEX <u>female</u>			
6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 25, 1961</u>		9. AGE (In years last birthday) <u>13</u> IF UNDER 1 YEAR <u>13</u> IF UNDER 24 HRS. <u>13</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co., Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Jack Hitt, Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Robin Burris</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Robin Hitt</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural hemorrhage</u> DUE TO (b) <u>Prenatal injury (?)</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>—</u>							
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>			
20f. (City or town) <u>—</u>		20g. (County) <u>—</u>		20h. (State) <u>—</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>2-25-61</u> to <u>2-26-61</u>, that (I) (we) last saw the deceased alive on <u>2-26-61</u>, and that death occurred on <u>2-26-61</u>, from the causes and on the date stated above.							
22a. SIGNATURE <u>Ira Peat-Iman</u> M.D.				22b. DATE SIGNED <u>—</u>			
22c. PHYSICIAN'S NAME (Type) <u>Ira Peat-Iman</u>				22d. ADDRESS <u>4700 Bradley Blvd. Beth., Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/28/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>			
23d. LOCATION (City, town or county) <u>Gaithersburg, Maryland</u>		23e. (State) <u>—</u>		23f. (Country) <u>—</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland</u>				25a. REC'D BY REGISTRAR <u>—</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				DATE <u>MAR 1 '61</u>			

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is not a physician, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2098

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02075

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 721 Ritchie Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 721 Ritchie Ave.		a. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clarence Norman Hohenberger	4. DATE OF DEATH Feb. 10, 1961	5. SEX male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 11/24/1900	9. AGE (In years, birth day, month, days, hours, m. n.) 60	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railway Exp. agency	
10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Hohenberger	14. MOTHER'S MAIDEN NAME Unknown	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.	17. INFORMANT Fannie Hohenberger *	Address Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 2/10/61	
EXAMINER'S NAME (Type) Frank J. Broschart	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, DATE THEREOF Burial Feb-13-1961	22b. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22c. LOCATION (City, town, or county) (State) Prince Geo. Co. Md.	
23. FUNERAL DIRECTOR J. Arthur Walters, 254 Camillus Rd DC	24a. REC'D BY REGISTRAR FEB 14 '61 24b. REGISTRAR'S SIGNATURE Arthur L. Thomas		

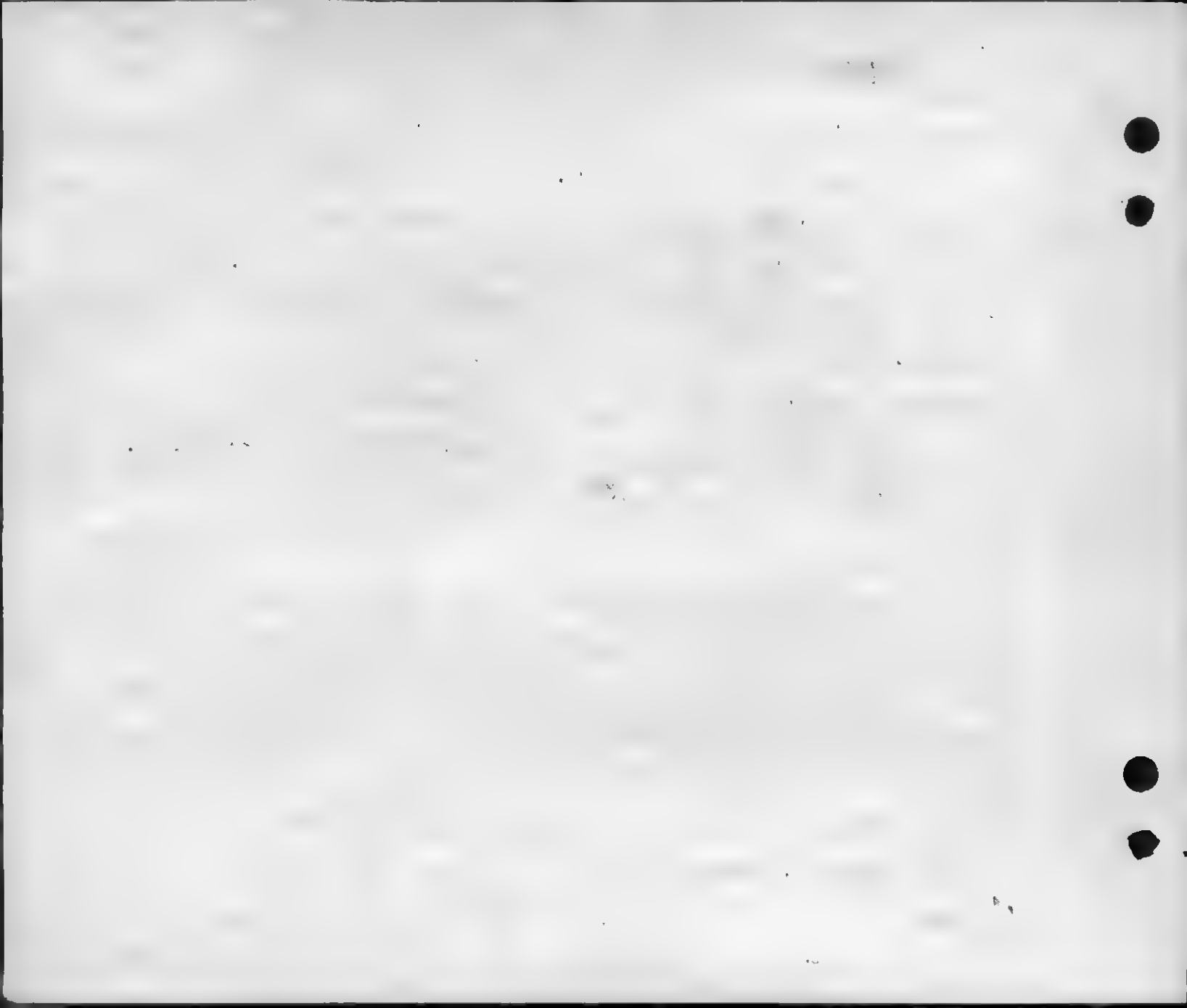


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any copy is necessary, it should be retained for the files. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				
c. LENGTH OF STAY IN I.D. 8 Hrs.					d. STREET ADDRESS 110 Calvert Road				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Catherine Lee Hunt					4. DATE OF DEATH Feb. 17 1961				
5. SEX Female					6. COLOR OR RACE White				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 2/27/23				
9. AGE (In years last birthday) 37 yrs.					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Reg. Nurse				
11. BIRTHPLACE (State or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? Alma Geiger (mother) Cumberland, Md.				
13. FATHER'S NAME Benjamin Zembower					14. MOTHER'S MAIDEN NAME Alam Ruehl				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. Box 683 Rt#1				
17. INFORMANT Alma Geiger (mother)					Address Cumberland, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Herniation of brain stem DUE TO (b) Intercentral edema DUE TO (c) Cerebral laceration due to bullet wound									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) multiple bullet wounds in torso & extremities									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year 8:30 p.m. 2-14 1961									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street									
20f. (City or town) Rockville (County) Montgomery (State) Md.									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
Address (Street, c. ty, town, or county) 2-17-61									
ACTUAL SIGNATURE Frank J. Brochart M.D.									
EXAMINER'S NAME (Type) Frank J. Brochart									
DATE SIGNED 2-17-61									
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal									
22b. DATE THEREOF Feb. 20 1961									
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery Colmar Manor Md.									
22d. LOCATION (City, town, or country) (State)									
23. FUNERAL DIRECTOR Cherry Chase Funeral Home Wash. D.C.									
ADDRESS 5103 W. 4th St.									
24a. REC'D BY REGISTRAR FEB 23 '61									
24b. REGISTRAR'S SIGNATURE Arthur L. Huns									



1
FOR STATE
HEALTH DEPT.

TO DEPUTY DIRECTOR: This certificate should be executed within 4 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Frank J. Broschart

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

23. FUNERAL DIRECTOR

ROBERT A. PUMPHREY

Bethesda, Md.

24a. REC'D BY REGISTRAR
DATE FEB 21 '61

24b. REGISTRAR'S SIGNATURE
Charles S. Kraus

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give year or dates of service)

No

Unknown

17. INFORMANT 5225 Westpath Way, Sumner, Md.
John Hunt Bethesda, Md. (Brother)

MEDICAL CERTIFICATION

MEDICAL CERTIFICATION

I

1

1

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN 1b

DOA

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Suburban Hospital

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

Henry Jackson Hunt

Feb. 16

19 61

5 SEX

Male

6. COLOR OR RACE

white

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

12/9/1909

9. AGE (In years last birthday)

51

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Owner

10b. KIND OF BUSINESS OR INDUSTRY

Dog Kennels

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Henry J. Hunt

14. MOTHER'S MAIDEN NAME

ROSE WARDER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give year or dates of service)

No

16. SOCIAL SECURITY NO.

Unknown

17. INFORMANT 5225 Westpath Way, Sumner, Md.

John Hunt Bethesda, Md. (Brother)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Cerebral hemorrhage & laceration

INTERVAL BETWEEN ONSET AND DEATH
2 hr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

Bullet wound in rt skull

DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

self inflicted bullet wound

20c. TIME OF INJURY

Month, Day, Year

8:30 PM

2/16/61

20d. INJURY OCCURRED

While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

street

20f. (City or town)

Rockville Montg

(County)

(State)

Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER

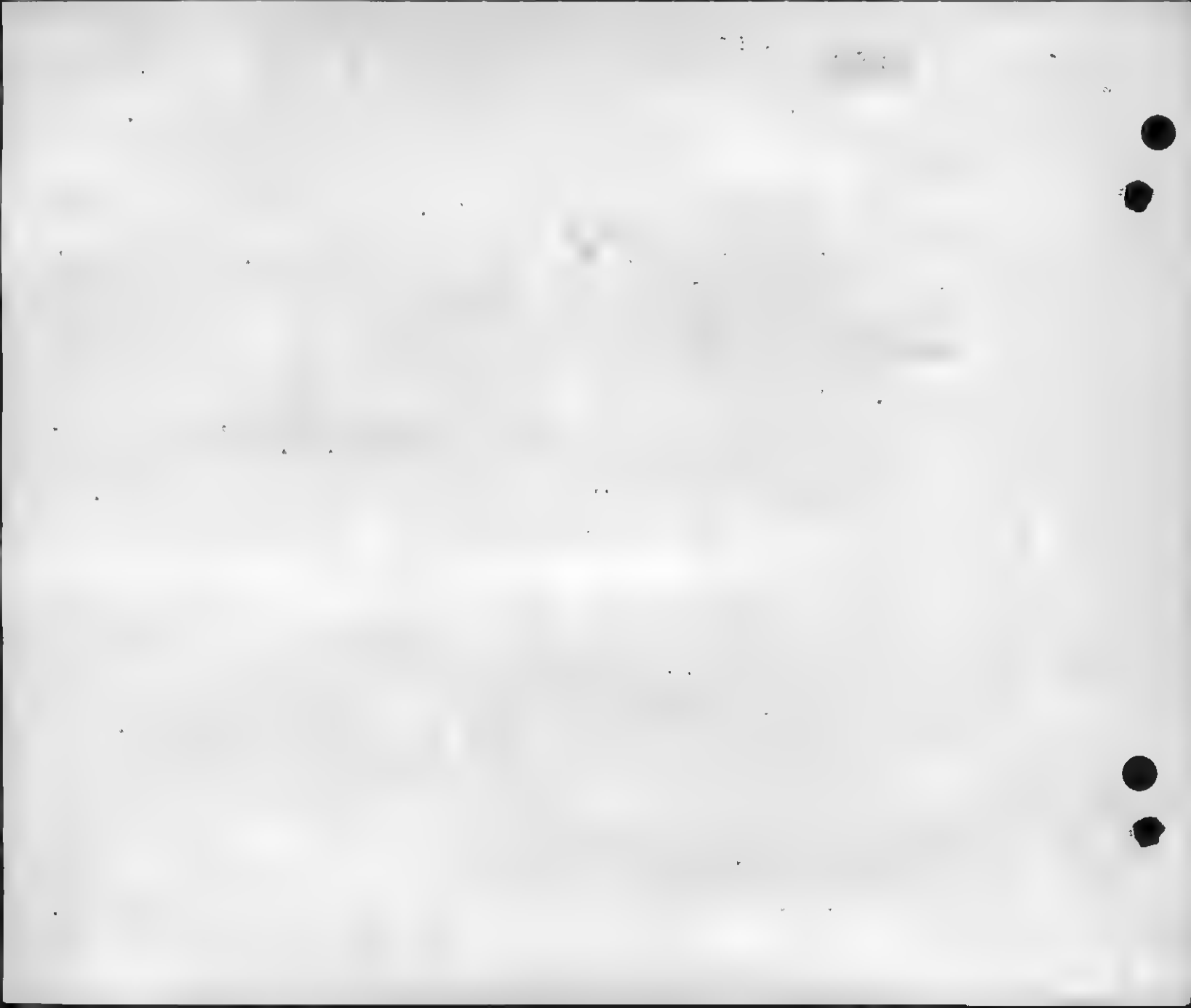
ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

DATE SIGNED

2/16/61



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the attending physician and completely filled in by the funeral director, may be retained by the hospital or attending physician. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2101

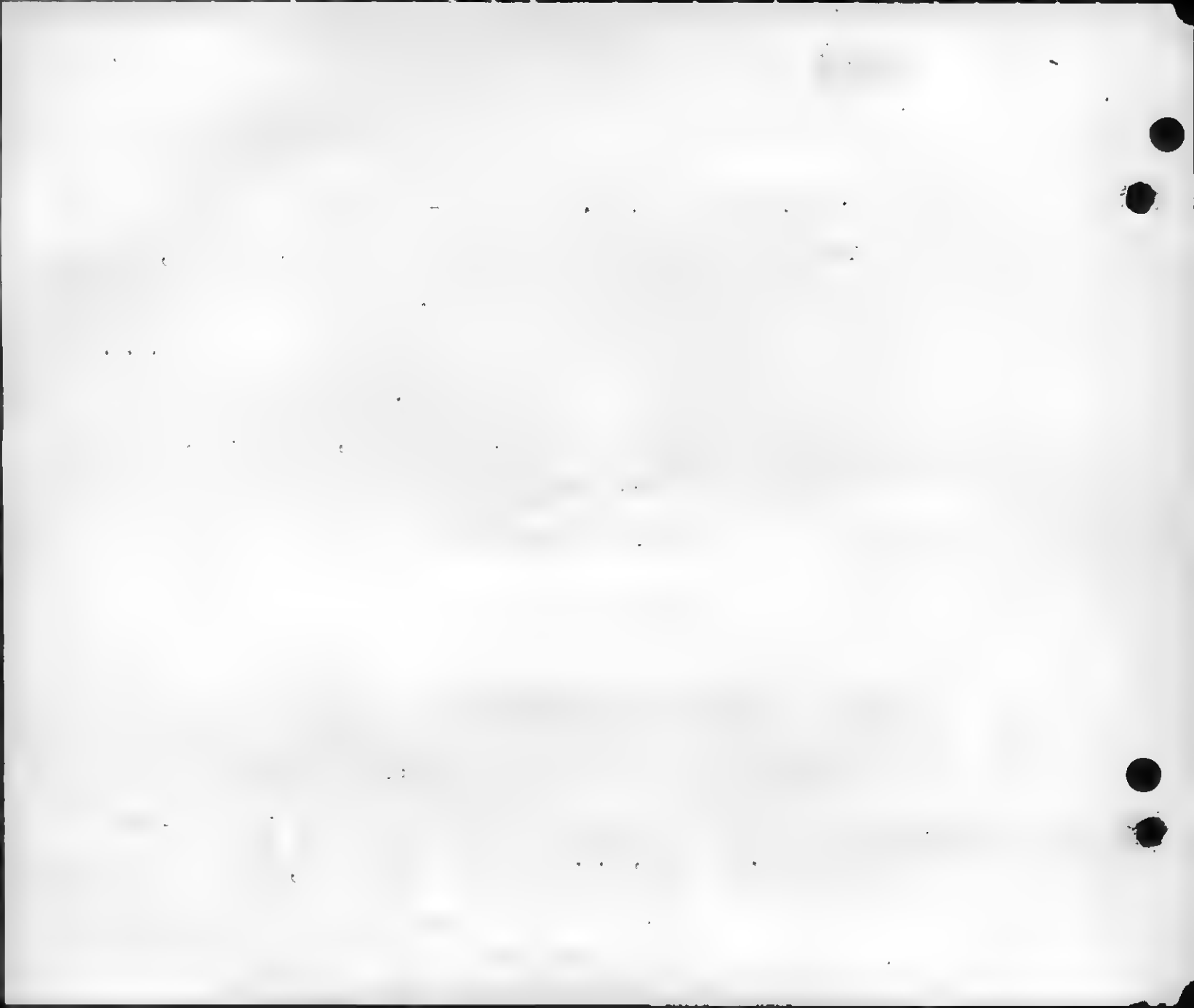
02078

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN lb 7 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookmont	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 4020 - 64th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lina Middle Dorothy Last James				4. DATE OF DEATH Month February Day 28, Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 14, 1888	
9. AGE (In years last birthday) 72 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer				10b. KIND OF BUSINESS OR INDUSTRY Office		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Otto Jahn				14. MOTHER'S MAIDEN NAME Lina D. Stephanson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO				16. SOCIAL SECURITY NO Unascertainable		17. INFORMANT The Medical Records Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Coronary Arteriosclerosis (b) Coronary Arteriosclerosis DUE TO (c) Coronary Arteriosclerosis CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
INTERVAL BETWEEN ONSET AND DEATH 10 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lymphoma							
20a. ACC. DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that 74 (this hospital) attended the deceased from February 21 1961 to February 28 19 61 , that 74 (we) last saw the deceased alive on February 28 19 61 , and that death occurred at 10:10PM from the causes and on the date stated above.							
22a. SIGNATURE H. J. Gitelman M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 3/1/61		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Hillel J. Gitelman, M.D.				22d. ADDRESS The Clinical Center National Institutes Of Health Bethesda 14, Maryland			
23a. BURIAL CREMATION, REMOVAL (Specify) Bur-Transit		23b. DATE THEREOF 3/3/61		23c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Mem. Park		23d. LOCATION (City, town, or county) (State) Paramus, New Jersey	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				25a. REC'D BY REGISTRAR DATE MAR 3 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

M

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2



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2102

02073

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park 12</u>				c. LENGTH OF STAY IN 1b <u>1 month</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oak Haven Convalescent Home</u>				e. STREET ADDRESS <u>6745 Eastern Ave 1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles O Johnson</u>				4. DATE OF DEATH Month Day Year <u>Feb 15 1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 29, 1877</u>	9. AGE (n years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocer</u>		11. BIRTHPLACE (State or foreign country) <u>Scott Co, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Benham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mrs. Blanche Webb's 745 Eastern Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, Smiling, Recent Cerebral Vascular accident</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None.</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>— 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1956</u> to <u>15 Feb. 1961</u> , that (I) (we) last saw the deceased alive on <u>2-15-1961</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Frederick Barr</u>				22b. DATE SIGNED <u>2-15-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>FREDERICK BARR, MD</u>				22d. ADDRESS <u>College Park, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>2/18/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ledar Hill Cem On</u>		23d. LOCATION (City, town, or county) (State) <u>Geo Co Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. K. Huntman & Son</u>				25a. REC'D BY REGISTRAR <u>FEB 20 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02080

2103

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CONGRESSIONAL MANOR SANITARIUM</u>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>9303 Bull Run Parkway 1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ethel</u> First <u>Johnson</u> Middle <u>Johnson</u> Last 5. SEX <u>F</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>Jan. 9 1881</u> 9. AGE (In years last birthday) <u>80</u> yrs 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				4. DATE OF DEATH <u>Feb 18 1961</u> Month <u>Feb</u> Day <u>18</u> Year <u>1961</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS	
13. FATHER'S NAME <u>W. M. JOHNSON</u>				14. MOTHER'S MAIDEN NAME <u>Antitia JONES</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.				17. INFORMANT				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Heart Disease</u> <u>4500</u> DUE TO (b) <u>UREMIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>ART-HYPERTENSION 14</u>								INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>NOV. 18, 1955</u> to <u>FEB. 18, 1961</u> , that (I) (we) last saw the deceased alive on <u>FEB. 16, 1961</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above									
22a. SIGNATURE <u>Joseph H. Leonard</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>FEB. 18, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>Joseph H. Leonard</u>				22d. ADDRESS <u>5421 N. ...</u>					
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>2/19/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>		23d. LOCATION (City, town, or county) <u>Culpeper</u> (State) <u>Virginia</u>		25a. REC'D BY REGISTRAR <u>Cheng Chan</u> DATE <u>FEB 24 '61</u>	
24. REGISTRAR'S SIGNATURE <u>Cheng Chan</u>				ADDRESS <u>5763 Wisconsin Ave Washington, D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Cheng Chan</u>			

(M)

(I)



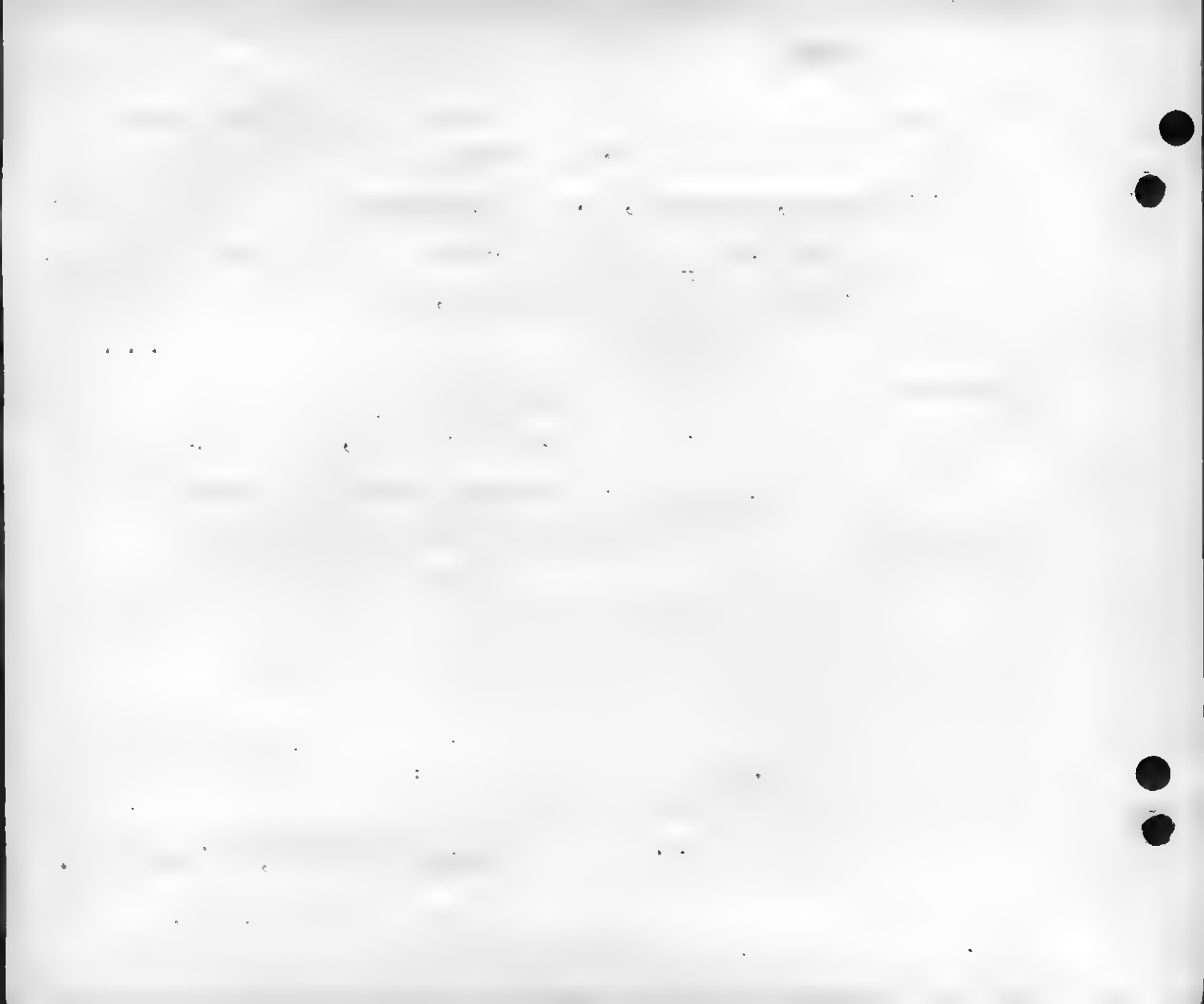
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2104

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02081

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 65 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR IN INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park d. STREET ADDRESS 8217 Roanoke Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mabelle Middle Pearl Last Johnson			4. DATE OF DEATH Month February Day 12 Year 19 61				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11, 1898		9. AGE (In years last birthday) 62		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Illinois			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Arthur Buss			14. MOTHER'S MAIDEN NAME Cora Dawes				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra abdominal hemorrhage secondary to metastatic 1950 DUE TO adrenal cortical carcinoma of liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adrenal cortical carcinoma metastatic to lungs and DUE TO liver (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 30 hours INTERVAL BETWEEN ONSET AND DEATH 9 Months							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from December 9, 1960 to February 12, 1961 , that (I) (we) last saw the deceased alive on Feb. 12, 1961 , and that death occurred at 4:40 AM from the causes and on the date stated above.							
22a. SIGNATURE <i>Martin Nydick M.D.</i>		22b. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.		22c. PHYSICIAN'S NAME (Type) Martin Nydick M.D.			
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.		22e. DATE 2/12/61		22f. SIGNATURE <i>Arthur L. Hume</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE THEREOF 2/13/61		23c. NAME OF CEMETERY OR CREMATORY Ladies Union Cemetery			
23d. LOCATION (City, town, or county) Stockton, Ill.		23e. STATE Ill.		23f. COUNTY Ill.			
24. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Jones Co.</i>		24a. ADDRESS 2901-14th St. NW		24b. DATE Feb 14 1961			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

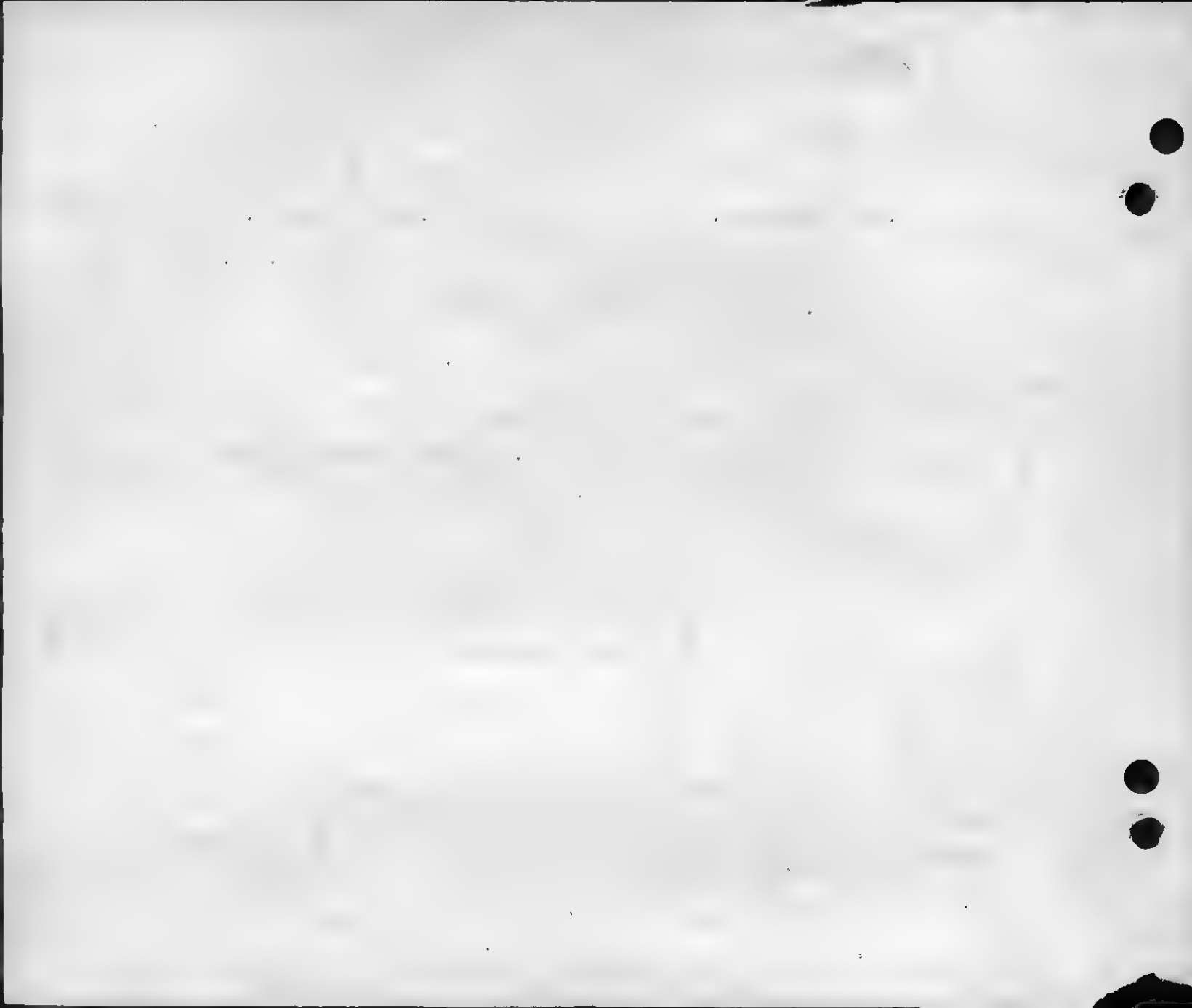
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2105 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02082

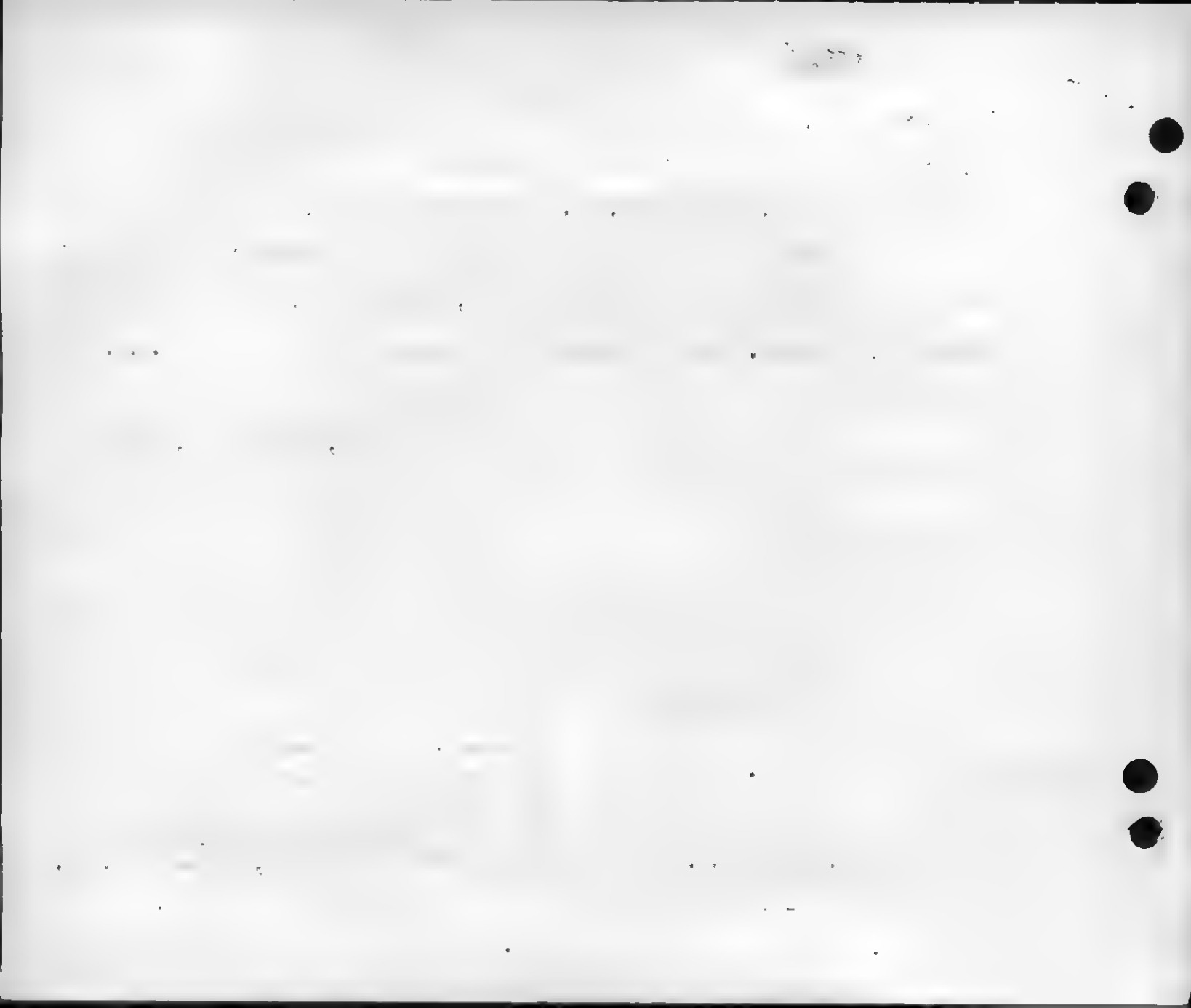
1. PLACE OF DEATH a. COUNTY <u>Sadie Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN lb <u>40 years</u>		d. STREET ADDRESS <u>222 N. Washington St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>222 N. Washington St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sadie Frances Johnson</u>		4. DATE OF DEATH <u>Feb. 18, 1961</u>	
5. SEX <u>female</u>		6. COLOR OR RACE <u>col.</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/26/1887</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR: Months <u>73</u> Days <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Burrell Nelson</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Wyatt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>I</u>		16. SOCIAL SECURITY NO. <u>Geo. Johnson (husband)</u>	
17. INFORMANT <u>Item 2</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>42'0.1</u> <u>Coronary occlusion</u> DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u></u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/22/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		24a. REC'D BY REGISTRAR <u>Feb 24 '61</u>	
ADDRESS <u>Rockville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
2106
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
02083

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 95 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Minnesota b. COUNTY Brainerd c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brainerd d. STREET ADDRESS 223 North 8th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Caroline Jones			4. DATE OF DEATH Month Day Year February 5 1961		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH June 1, 1908		9. AGE (In years last birthday) 52 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Ernest Jones			14. MOTHER'S MAIDEN NAME Caroline Moe		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Carcinoid DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 yrs.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from November 2, 1961 to February 5, 1961 , that (I) (we) last saw the deceased alive on Feb. 5, 1961 , and that death occurred at 7am , from the causes and on the date stated above. 22a. SIGNATURE Michael Z. Lazor M.D. 22b. DATE SIGNED 2/6/61 22c. PHYSICIAN'S NAME (Type) Michael Z. Lazor, M.D. 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		23b. DATE THEREOF 2-7-61		23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR DATE FEB 14 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hand	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2107 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02184

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b Bethesda Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4904 Hampden Lane		d. STREET ADDRESS 9010 Old Georgetown Rd.	
3. NAME OF DECEASED (Type or print) Ira E. Keller		4. DATE OF DEATH Month 2 Day 3 Year 19 61	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-1-1885
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 11 Days 11	IF UNDER 24 HRS. Hours 11 Min. 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	11. BIRTHPLACE (State or foreign country) Missouri
13. FATHER'S NAME Henry Keller		14. MOTHER'S MAIDEN NAME Mary Burris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-32-5558	
17. INFORMANT Wife Margaret T. Keller		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conorary Occulsion (Sudden) DUE TO (b) 4-0-0 Conditions, if any, which gave rise to immediate cause (c) 4-0-0 DUE TO (c) 4-0-0 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Brosch		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BROSCHE		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 2-4-61	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-10-61	
22c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		22d. LOCATION (City, town, or county) (State) Beallsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE FEB 8 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	



1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2108
CERTIFICATE OF DEATH
0208

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 29 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle E. Last King				4. DATE OF DEATH Month February Day 4 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 7, 1898	
9. AGE (In years last birthday) 63 yrs		10. IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min 0		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME William E. Clapp				14. MOTHER'S MAIDEN NAME Anna Hudson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. ---		17. INFORMANT (Husband) Alfred M. King Address As above # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Cervix ectocervix 171X DUE TO (b) 171X DUE TO (c) 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from Jan 6 19 61 to Feb 4 19 61 , that (we) last saw the deceased alive on 4 Feb 19 61 and that death occurred at 4 M, from the causes and on the date stated above.							
22a. SIGNATURE H. C. Magary M. D.				22b. ADDRESS 829 Veershield Rd Rockville			
22c. PHYSICIAN'S NAME (Type) H. C. Magary				22d. ADDRESS 829 Veershield Rd Rockville			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Febr. 7, 1961		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Prince Georges Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Callaway ADDRESS 254 Carroll Wash. D.C.				25a. REC'D BY REGISTRAR DATE FEB 8 '61		25b. REGISTRAR'S SIGNATURE Charles S. Fenn	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2109

Item 9 filing 2-14-61 et

02086

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>730 The Sda 10 days 10 hrs 1 Chevy Chase</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <u>13616 Taylor St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Raymond W. King</u> First Middle Last 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>7/5/87</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>73</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH <u>Feb 3 1961</u> Month Day Year 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Investigation (retired) U.S. Govt</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Va.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Adolphus King</u> 14. MOTHER'S MAIDEN NAME <u>Harriet</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> 16. SOCIAL SECURITY NO. <u>216-40-9615</u> 17. INFORMANT <u>Margaret B. King</u> Address <u>3616 Taylor St. Chevy Chase, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct acute and</u> <u>420.1</u> DUE TO (b) <u>Arterio sclerosis.</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Rt. hemiplegia, aphasia, cardiac failure.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>1953</u> , to <u>Feb. 3</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>February 2, 1961</u> , and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Irene G. Tamagna</u> 22c. PHYSICIAN'S NAME (Type) <u>IRENE G. TAMAGNA M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>7101 Conn. Ave Chevy Chase 15, Md.</u> 22b. DATE SIGNED <u>2/3/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2/7/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>FEB 8 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

1978

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **112087**

2110

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN lb 2 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 4 7X-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4932 Bethesda Avenue				d. STREET ADDRESS 3760-39th St. N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Newell Last Kinnaird				4. DATE OF DEATH Month February Day 21 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/27/1884	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 5 Day 28		IF UNDER 24 HRS Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer				10b. KIND OF BUSINESS OR INDUSTRY U. S. Army		11. BIRTHPLACE (State or foreign country) Indiana	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Robert Kinnaird				14. MOTHER'S MAIDEN NAME Emma Newell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 434-44-8507		17. INFORMANT Address Virginia Kinnaird-cousin			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO cause last. (c) 							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 2/25/61		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE FEB 24 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hearn			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02085

2111

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Gaithersburg R.F.D. #2</u>				c LENGTH OF STAY IN 1b <u>2 yrs</u>			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ammons Nursing Home</u>				d. STREET ADDRESS <u>10X-7</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>James</u> Last <u>Kosh</u>				4. DATE OF DEATH Month <u>February</u> Day <u>14</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>201</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 14, 1868</u>	
9 AGE (In years last birthday) <u>92</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11 BIRTHPLACE (State or foreign country) <u> </u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James Kosh</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca</u>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u> </u>		17 INFORMANT <u>Nursing Home Records</u> Address <u> </u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis.</u> <u>Senility.</u> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost (b) <u> </u> DUE TO (c) <u>Generalized Arteriosclerosis.</u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. <u> </u> Day. <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>1959</u> , 19 <u> </u> , to <u>2/14</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>2/14</u> , 19 <u>61</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above							
22a SIGNATURE <u>Luciano P. Leal</u> M D				22b. ADDRESS <u> </u>			
22c. PHYSICIAN'S NAME (Type) <u>Luciano P. Leal</u>				22b. DATE SIGNED <u>2/17/61</u>			
23a BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>2/16/61</u>		23c NAME OF CEMETERY OR CREMATORY <u>Ash Memorial Cemetery</u>		23d LOCATION (City, town or county) (State) <u>Sandy Springs Md</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Robert J. [Signature]</u> ADDRESS <u> </u>				25a REC'D BY REGISTRAR <u> </u> DATE <u>FEB 24 '61</u>		25b REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reviewed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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2112

CERTIFICATE OF DEATH

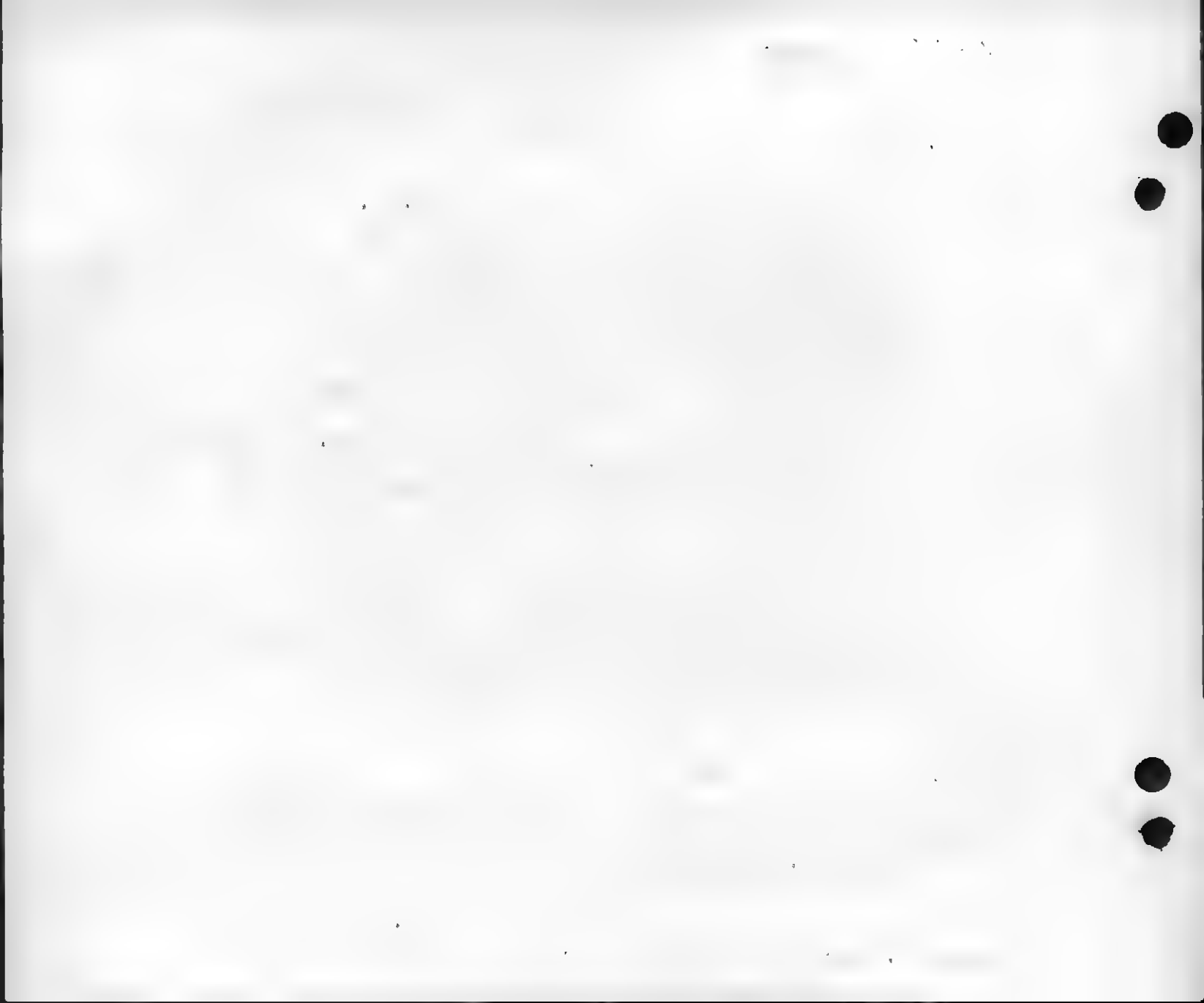
Reg. Dist. No.

02089

1 PLACE OF DEATH a. COUNTY Montg MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institut on. Residence before admission) a STATE Maryland b COUNTY Montg	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Germantown		c. LENGTH OF STAY IN TB 20 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown Rural	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS Brink. Rd.	
3 NAME OF DECEASED (Type or print) First Martha Middle Ann Last Laforce		4 DATE OF DEATH Month Feb Day 20 Year 19 61	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 19-1883
9. AGE (In years last birthday) 77 yrs	IF UNDER 1 YEAR Months 9 Days 1 Hours Min. 	IF UNDER 24 HRS Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Home Work	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U S A	
13 FATHER'S NAME William Smith		14 MOTHER'S MAIDEN NAME Darcus Embury	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
INFORMANT John L. Laforce. Germantown. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4-2-2-1 DUE TO (b) 5 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 28, 1956 to February 20, 1961 , that I last saw the deceased alive on February 18, 1961 , and that death occurred at Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 			
ACTUAL SIGNATURE James P. Kern		M.D. 2015 113, 4 No 4	
PHYSICIAN'S NAME (Type) James P. Kern M.D.		Baltimore, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-23-61	22c. NAME OF CEMETERY OR CREMATORY Germantown Baptist Ch.	22d. LOCATION (City, town, or county) (State) Germantown Md.
23 FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg. Md.		24a. REC'D BY REGISTRAR DATE FEB 23 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

TO HOSPITALS: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

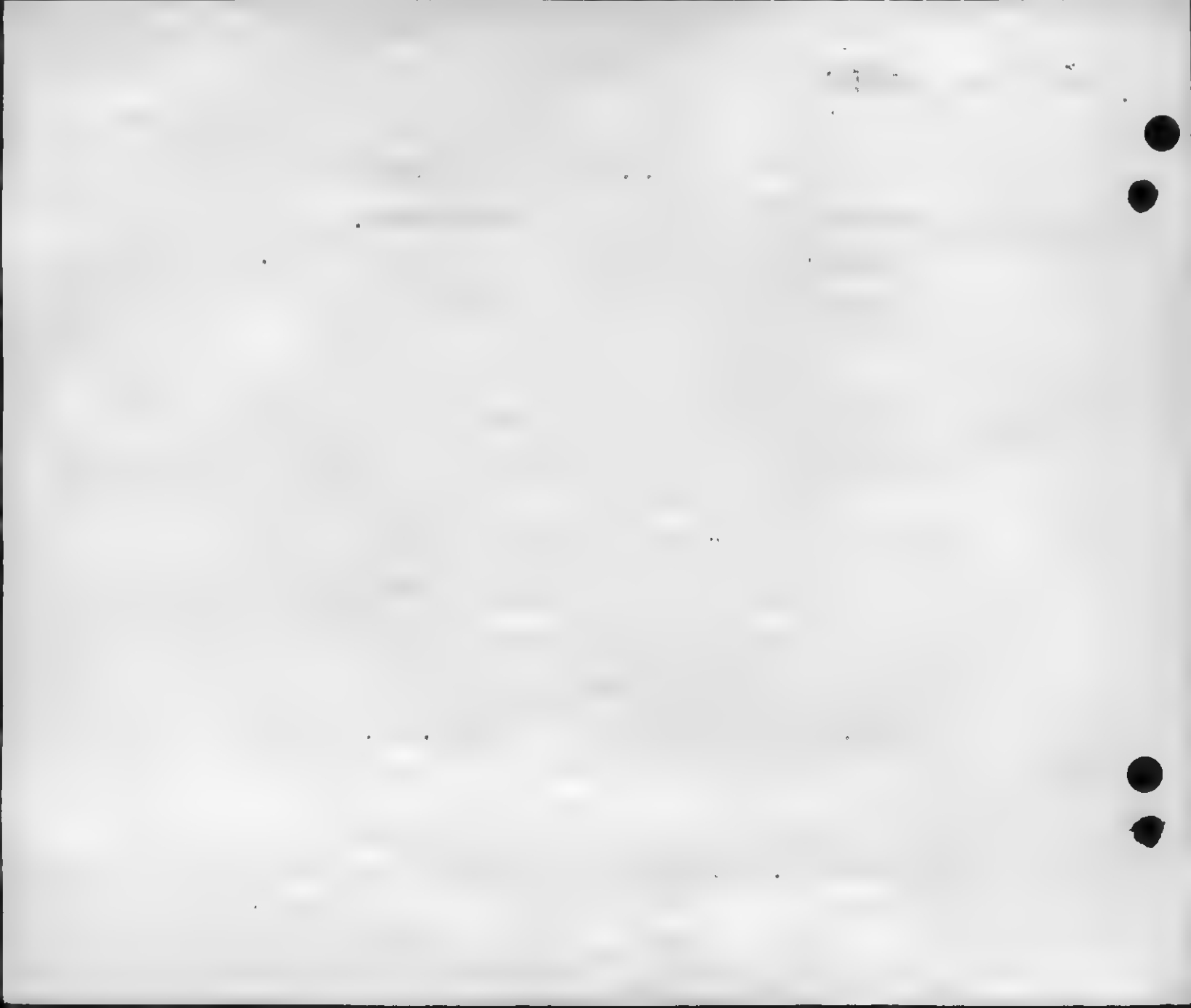
VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02090

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
c. LENGTH OF STAY IN TB <u>D.O.A.</u>		d. STREET ADDRESS <u>4012 Everett St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Eleanor Anne Lawrence</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>3</u> Year <u>1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/18/32</u>	
9. AGE (In years last birthday) <u>28</u> yrs.		10. IF UNDER 1 YEAR Months <u>28</u> Days <u>28</u> Hours <u>28</u> Min. <u>28</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Historian N.I.H.</u>		11. BIRTHPLACE (State or foreign country) <u>Mass.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Albert F. Lawrence</u>	
14. MOTHER'S MAIDEN NAME <u>Gladys H. Morrill</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>A.S. Lawrence Jr.</u>		17. INFORMANT <u>John</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PA T I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> DUE TO (b) <u>Rupture, Internal Carotid Arteries</u> DUE TO (c) <u>Gunshot Wound, Head</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sudden</u> <u>Sudden</u>	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot in head by person unknown</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>Feb. 3</u> 19 <u>61</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Conn. Ave. Kensington</u>		20f. (City or town) (County) (State) <u>Montgomery Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brochart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Brochart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 2-6-61</u>		22b. DATE THEREOF <u>2-6-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Fitchburg, Mass.</u>	
23. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>FEB 8 61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>	



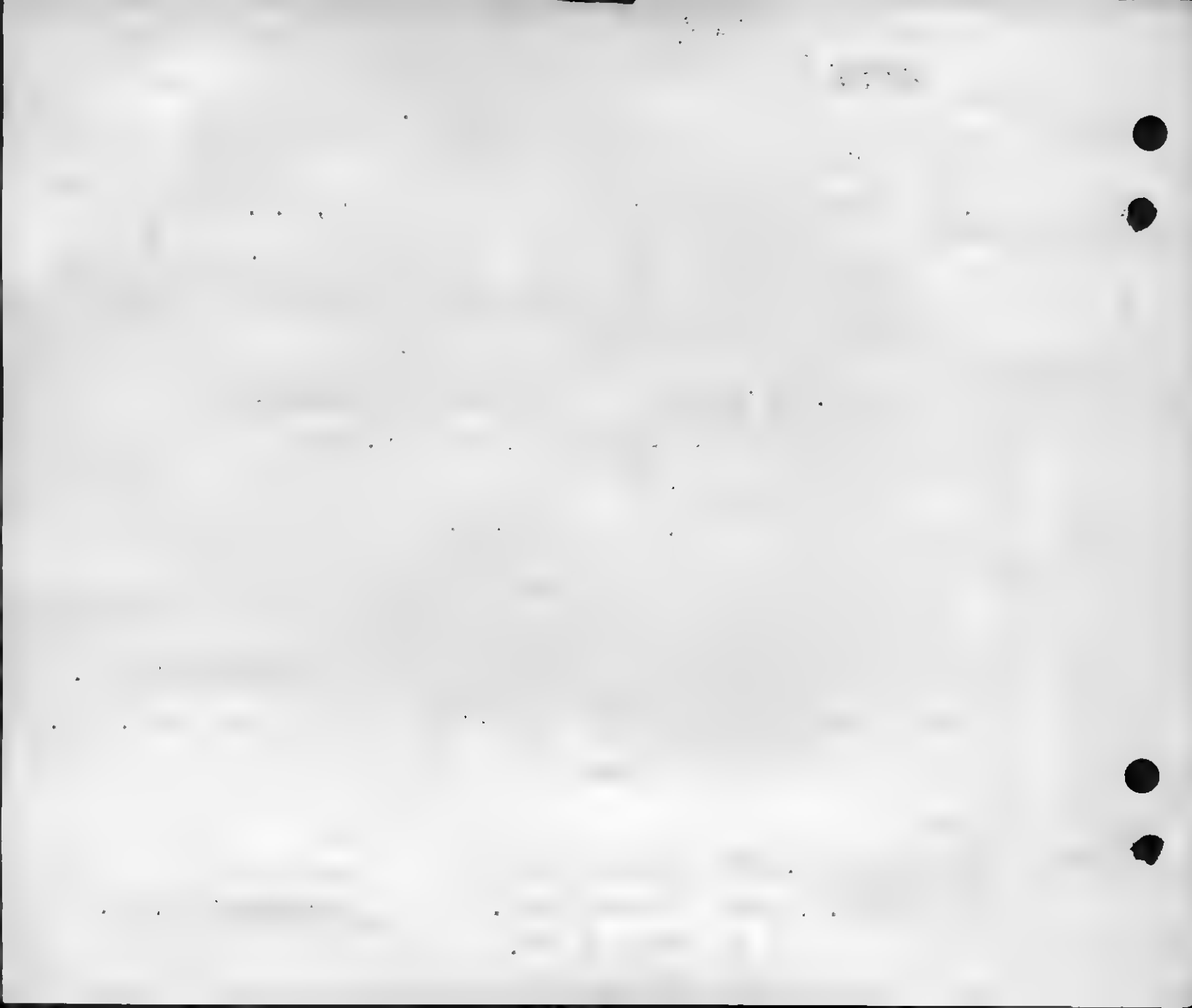
1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
02091									
1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN IL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D.C. b. COUNTY		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Ordinance Laboratory		e. STREET ADDRESS 6614 7th Place, N.W.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) William Filmore Lewis		First Middle Last		4. DATE OF DEATH Feb. 4 19 61		Month Day Year			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/11/1901		9. AGE (In years last birthday) 59 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machanic		10b. KIND OF BUSINESS OR INDUSTRY refrigeration		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William F. Lewis				14. MOTHER'S MAIDEN NAME Olive May Watkins					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW # 2				16. SOCIAL SECURITY NO. 578-03-7177		17. INFORMANT U.S. Naval Ord. record			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carbon dioxide poisoning DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 14.3						INTERVAL BETWEEN ONSET AND DEATH sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Refrigeration system dumped & released Carbon dioxide gas.					
20c. TIME OF INJURY 4:55 p.m.		Month, Day, Year 2/4/ 19 61		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) laboratory		20f. (City or town) (County) (State) Silver Spring, Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE Frank J. Broschart				M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/4/61	
EXAMINER'S NAME (Type) Frank J. Broschart				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Feb. 7, 1961		22c. NAME OF CEMETERY OR CREMATORY Bethesda Meth.		22d. LOCATION (City, town, or country) (State) Browningsville, Md.	
23. FUNERAL DIRECTOR Chin L. Moleworth				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR FEB 9 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Smith	

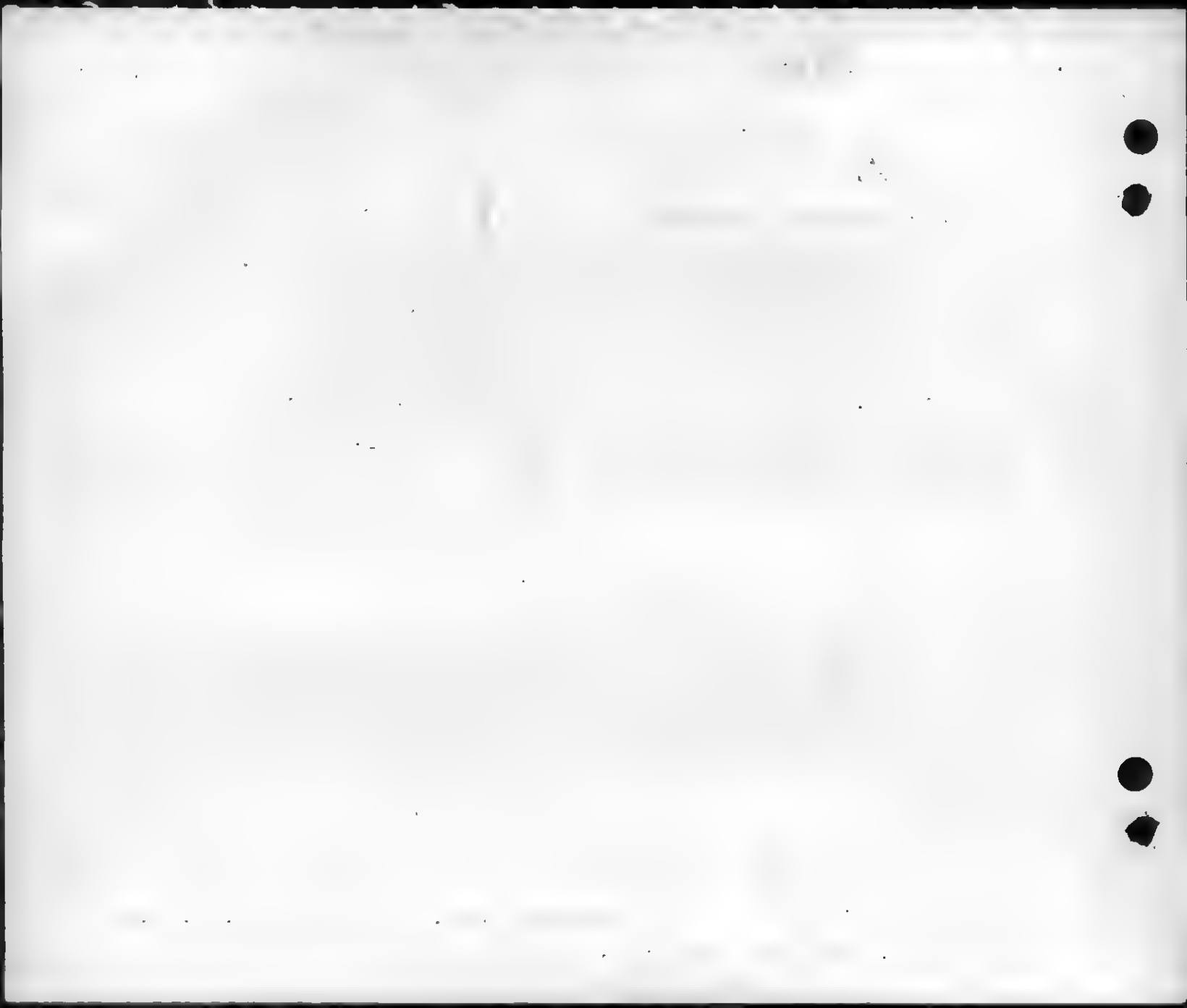


TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2115 CERTIFICATE OF DEATH

02092

1 PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6700 Bradley Boulevard</u>		e. STREET ADDRESS <u>6700 Bradley Boulevard</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Minnie</u> <u>(none)</u> <u>Low</u>		4. DATE OF DEATH Month Day Year <u>Feb.</u> <u>7</u> <u>1961</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1876</u>
9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>13</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		12. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
13. BIRTHPLACE (State or foreign country) <u>Maryland</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. FATHER'S NAME <u>John E. Low</u>		16. MOTHER'S MAIDEN NAME <u>Emma V. Heiberger</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		18. SOCIAL SECURITY NO. <u>None</u>	
19. INFORMANT <u>Kenneth Kelly-Nephew-same 2d</u>		Address	
1B CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Far Advanced Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> <u>8 years</u> <u>8 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>1951</u> to <u>1951</u> , that (I) (we) last saw the deceased alive on <u>2/12</u> 19 <u>61</u> , and that death occurred at <u>10:15</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Frank Y. Jagers Jr.</u> M.D.		22b. DATE SIGNED <u>2/7/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK Y. Jagers Jr.</u>		22d. ADDRESS <u>5707 Wisconsin Ave. Chevy Chase Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/9/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REG STRAR <u>FEB 14 '61</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. H. Jr.</u>	



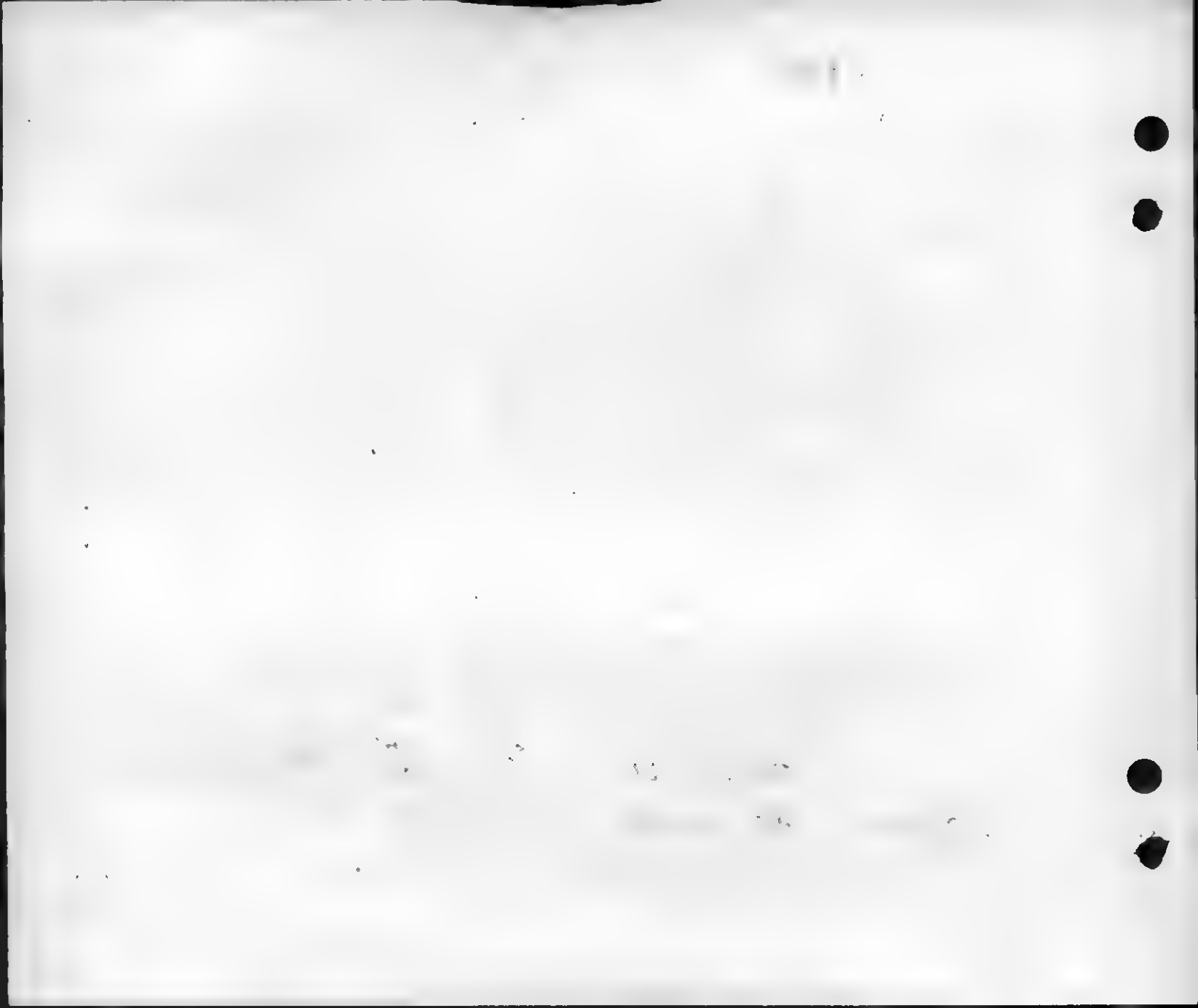
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02093

2116

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>DOA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San Hosp. 7600 Carroll Ave.</u>				d. STREET ADDRESS <u>309 Elm Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Samuel Knox Macatee</u>				4. DATE OF DEATH Month Day Year <u>February 4 1961</u>			
5 SEX <u>Male</u>		6 COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-18-00</u>	
9 AGE (In years last birthday) <u>61</u> yrs		IF UNDER 1 YEAR Months Days Hours Mm		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Scotland</u>	
13. FATHER'S NAME <u>John Boyd</u>				14. MOTHER'S MAIDEN NAME <u>Isabella Armstrong</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-09-9307</u>		17. INFORMANT Address <u>Hospital Records - Wash. San Hosp. T.P. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>3 min.</u> <u>20-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Atherosclerosis of coronary arteries</u> <u>6 yrs.</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> <u>20 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>2-12-1961</u> to <u>2-14-1961</u> , that (I) (we) last saw the deceased alive on <u>2-12-1961</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Charles T. Carroll</u> M.D.				22b. DATE SIGNED			
22c. (PHYSICIAN'S NAME) (Type) <u>Charles T. Carroll, M.D.</u>				22d. ADDRESS <u>6801 6th St. N.W. Wash. 12 D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 8, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery Prince George County Md.</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walter</u> ADDRESS <u>254 Carroll St NW DC</u>				25. REC'D BY REGISTRAR DATE <u>FEB 8 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur Walter</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO HOSPITAL OR DURING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

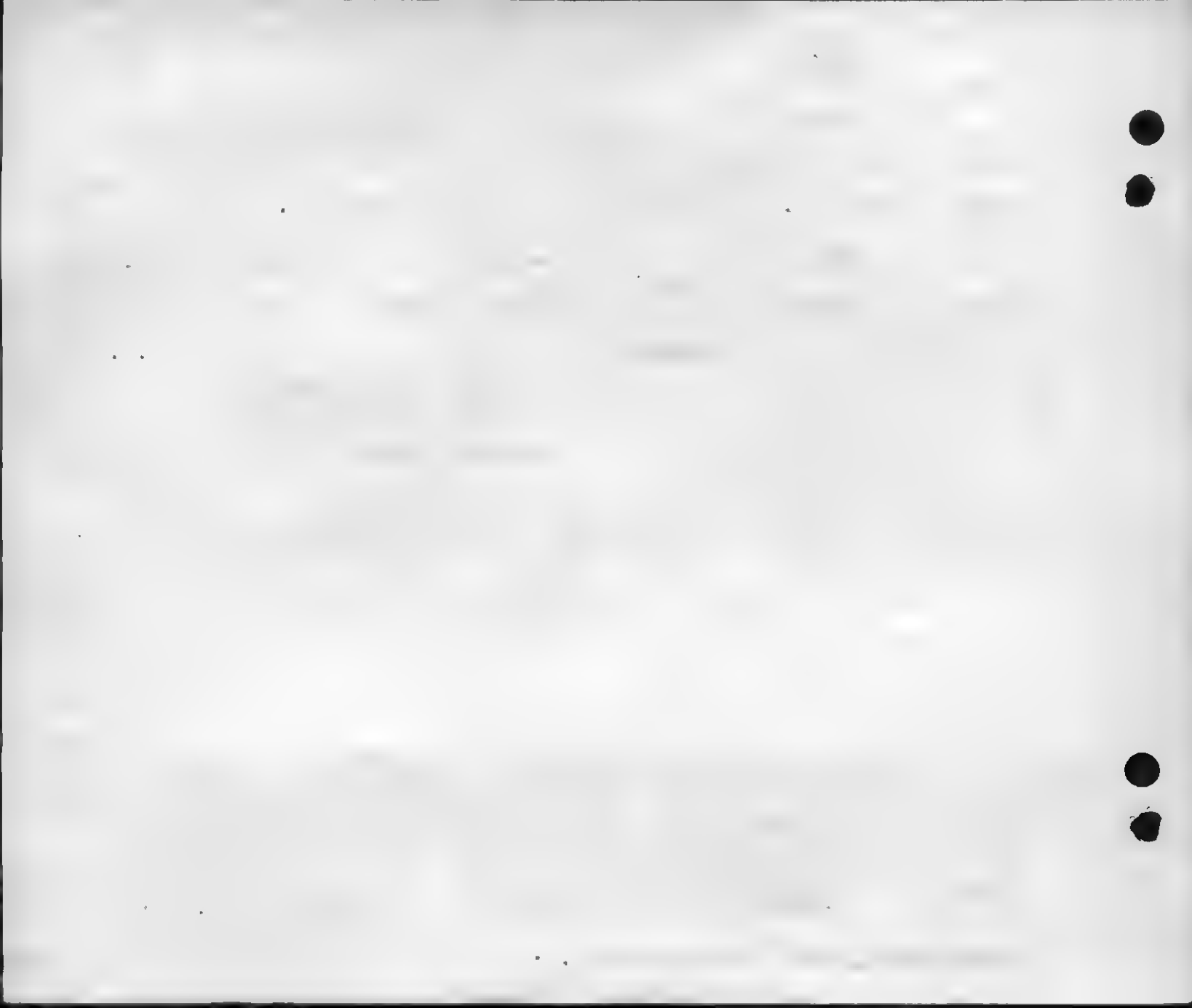
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2118

CERTIFICATE OF DEATH

02095

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2925 Terrace Dr.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 2925 Terrace Dr. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN First Middle Last		4. DATE OF DEATH February 13th, 1961 Month Day Year	
5. SEX Male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH June 24, 1887 9. AGE (In years last birthday) 73 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 10b. KIND OF BUSINESS OR INDUSTRY Merchant 11. BIRTHPLACE (County & State, or foreign country) Italy 12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME John B. Mandara		14. MOTHER'S MAIDEN NAME Antonetta Ziccardi	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Angelina Mandara Same as above Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure. DUE TO (b) Rheumatic Heart, Mitral & Aortic stenosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH 3 40 yrs +	
21. I certify that (I) (this hospital) attended the deceased from Feb 11 , 1960 to Feb 13 , 1961, that (I) (we) last saw the deceased alive on Feb 13 , 1961, and that death occurred at 5:35 M, from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE A. R. Damiano 22c. PHYSICIAN'S NAME (Type) Dr. J. D. Damian		22b. DATE SIGNED ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 2741 34th St NW, Wash. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-17-61	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town or county) (State) Bladensburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C. ADDRESS		25a. REC'D BY REGISTRAR FEB 16 '61 DATE 25b. REGISTRAR'S SIGNATURE Arthur S. Evans	



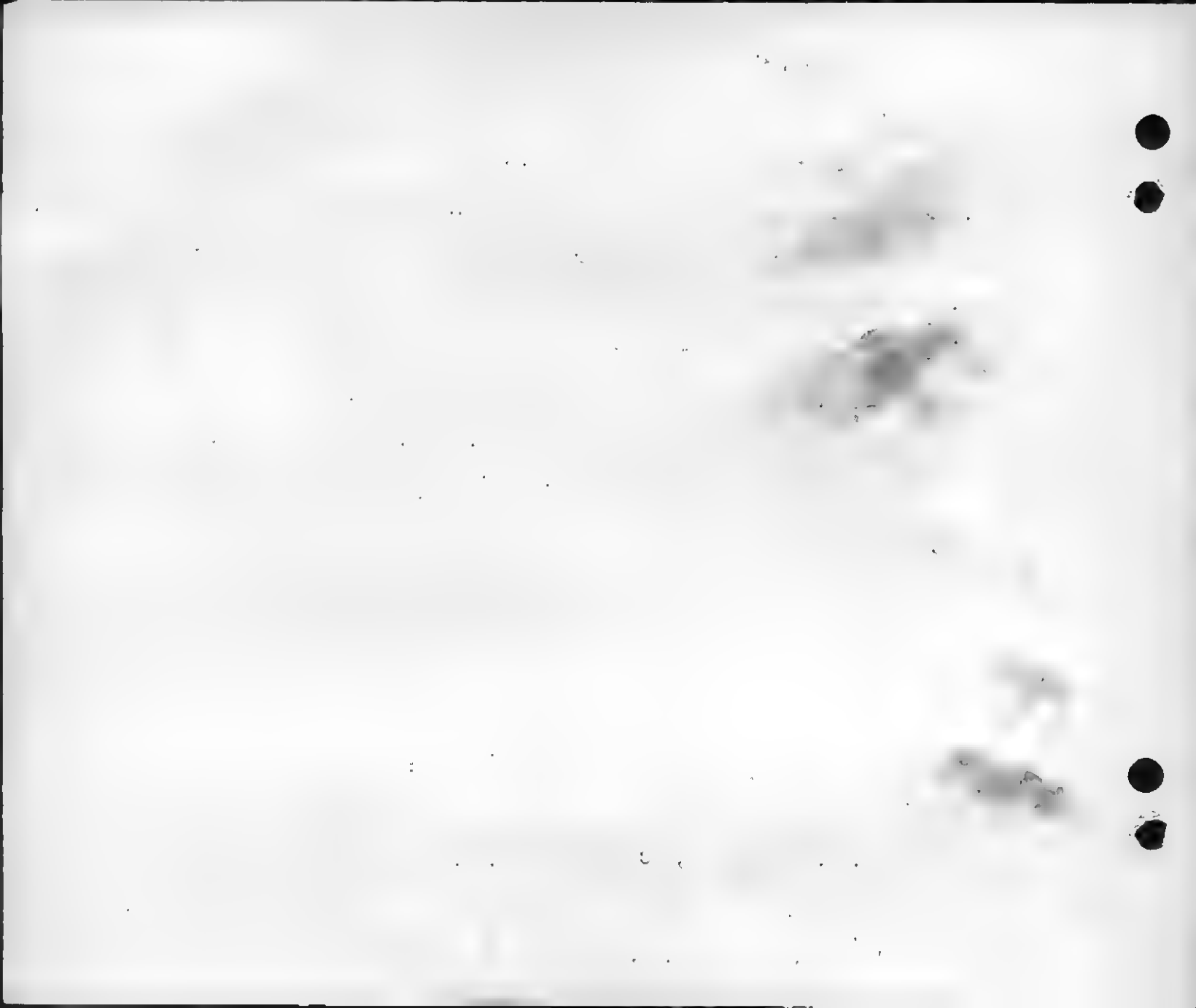
02096

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15M 9/59

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with-
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

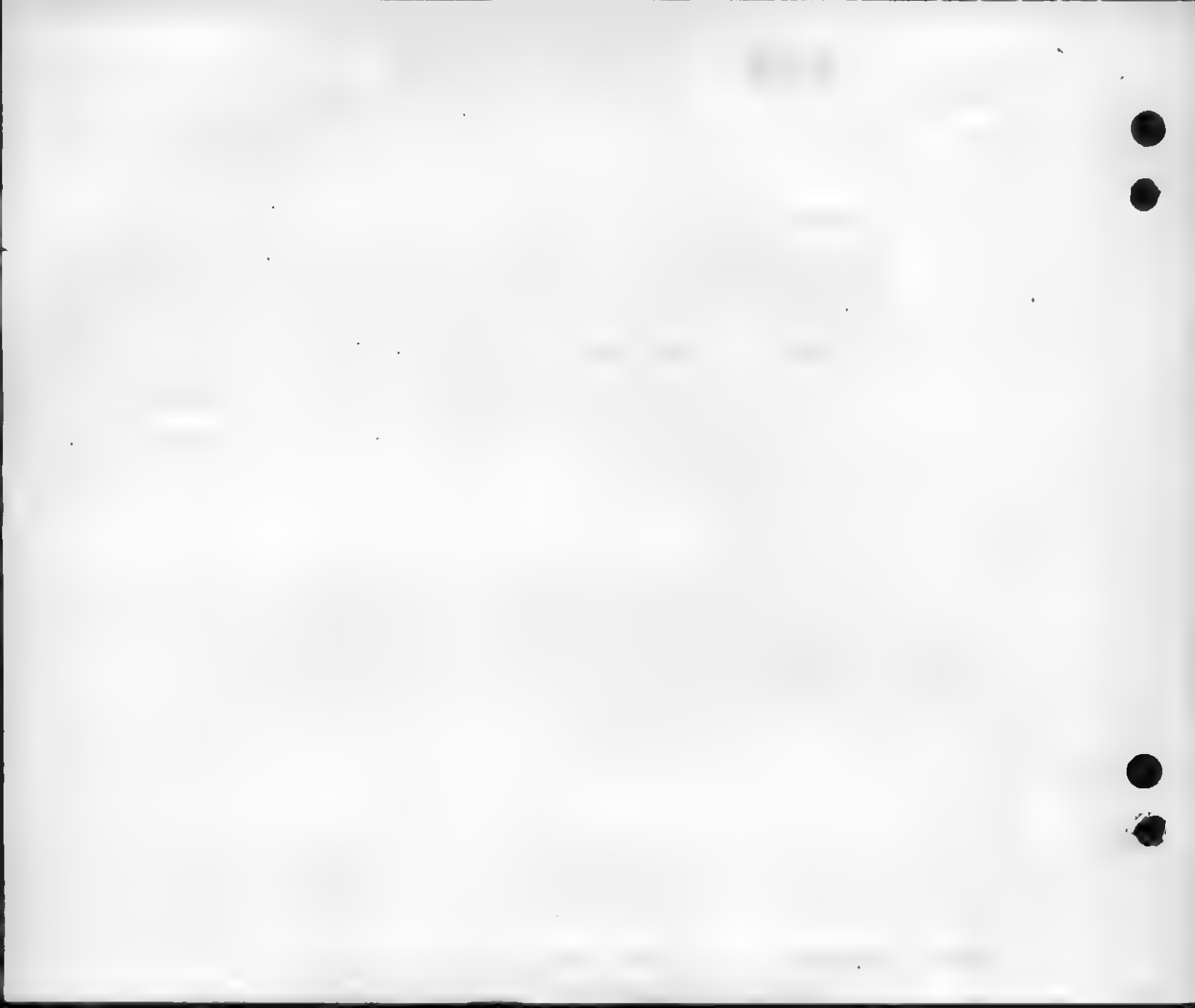
2120

0209

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 42			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>4911 Hampden Lane</u>			
3. NAME OF DECEASED (Type or print) <u>Wataro</u> First <u>Matsuoka</u> Middle <u>Matsuoka</u> Last				4. DATE OF DEATH <u>Feb 21</u> Month <u>21</u> Day <u>1961</u> Year			
5. SEX <u>male</u>		6. COLOR OR RACE <u>yellow</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 29, 1880</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fisherman</u>		11. BIRTHPLACE (State or foreign country) <u>Japan</u>		12. CITIZEN OF WHAT COUNTRY? <u>Japan</u>	
13. FATHER'S NAME <u>Hisaji Matsuoka</u>				14. MOTHER'S MAIDEN NAME <u>Matsuoka</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>339-24-8568</u>		17. INFORMANT <u>Ichiro Matsouka, Son-Chicago, Ill.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral malnutrition</u> <u>157X</u> DUE TO (b) <u>Intoxicated with alcohol</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (c) <u>Cerebral blood of pericard</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4-5 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, Electrolyte loss</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-21-1961</u> to <u>2-21-1961</u> , that (I) <u>last</u> saw the deceased alive on <u>2-21-1961</u> , and that death occurred <u>5:20 PM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Robert A. Humphrey</u> M. D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2-21-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert A. Humphrey M.D.</u>				22d. ADDRESS <u>4830 Northampton Rd., Bethesda, Md.</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>2/26/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>FEB 24 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Turner</u>	

Coroner notified and will approve.

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed in 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2121

1. PLACE OF DEATH
e. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lakema Park
c. LENGTH OF STAY in 1b 5 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington San & Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution Residence, list the institution)
e. STATE MARYLAND b. COUNTY Prince Georges
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hypothville
d. STREET ADDRESS 2526 Avalon Pl.

3. NAME OF DECEASED (Type or print) Henry (Wm.) Matthews
First Middle Last

4. DATE OF DEATH 2/10/61 19 19
Month Day Year

5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED ☒ NEVER MARRIED ☐ B. DATE OF BIRTH 10-15-14
WIDOWED ☐ DIVORCED ☐ 9. AGE (in years last birthday) 46 yrs. IF UNDER 1 YEAR: Months 1 Days 16 IF UNDER 24 HRS.: Hours 1 Min. 15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman 10b. KIND OF BUSINESS OR INDUSTRY Lustine Chevy 11. BIRTHPLACE (County & State, or foreign country) New York 12. CITIZEN OF WHAT COUNTRY? Amer. CA

13. FATHER'S NAME Edward Matthews 14. MOTHER'S MAIDEN NAME Molly Dorkman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? yes 16. SOCIAL SECURITY NO. 058-01-3403 17. INFORMANT p + Hosp Record. Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e) ACUTE MYOCARDIAL INFARCTION
420-1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO (c) PREVIOUS MYOCARDIAL INFARCTION 4 MONTHS AGO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e) PREVIOUS MYOCARDIAL INFARCTION 4 MONTHS AGO

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) AGO

20c. TIME OF INJURY Month, Day, Year: Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from OCTOBER 1955 to FEBRUARY 10, 1961, that (I) (we) last saw the deceased alive on FEBRUARY 10, 1961, and that death occurred at 7:00 PM, from the causes and on the date stated above.

22a. SIGNATURE Robert L. Krickmar M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ DATE FEBRUARY 10 1961
22c. PHYSICIAN'S NAME (Type) ROBERT L. KRICKMAR 22d. ADDRESS 7733 ALASKA AVE N.W. WASH 12 D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF FEB-12-1961 23c. NAME OF CEMETERY OR CREMATORY NAT'L MEM. PARK 23d. LOCATION (City, town or county) (State) FALLS CHURCH, VA.

24. FUNERAL DIRECTOR'S SIGNATURE Laedberg ADDRESS 4217 9th ST. S.W. 25a. REC'D BY REGISTRAR FEB 14 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Kinn



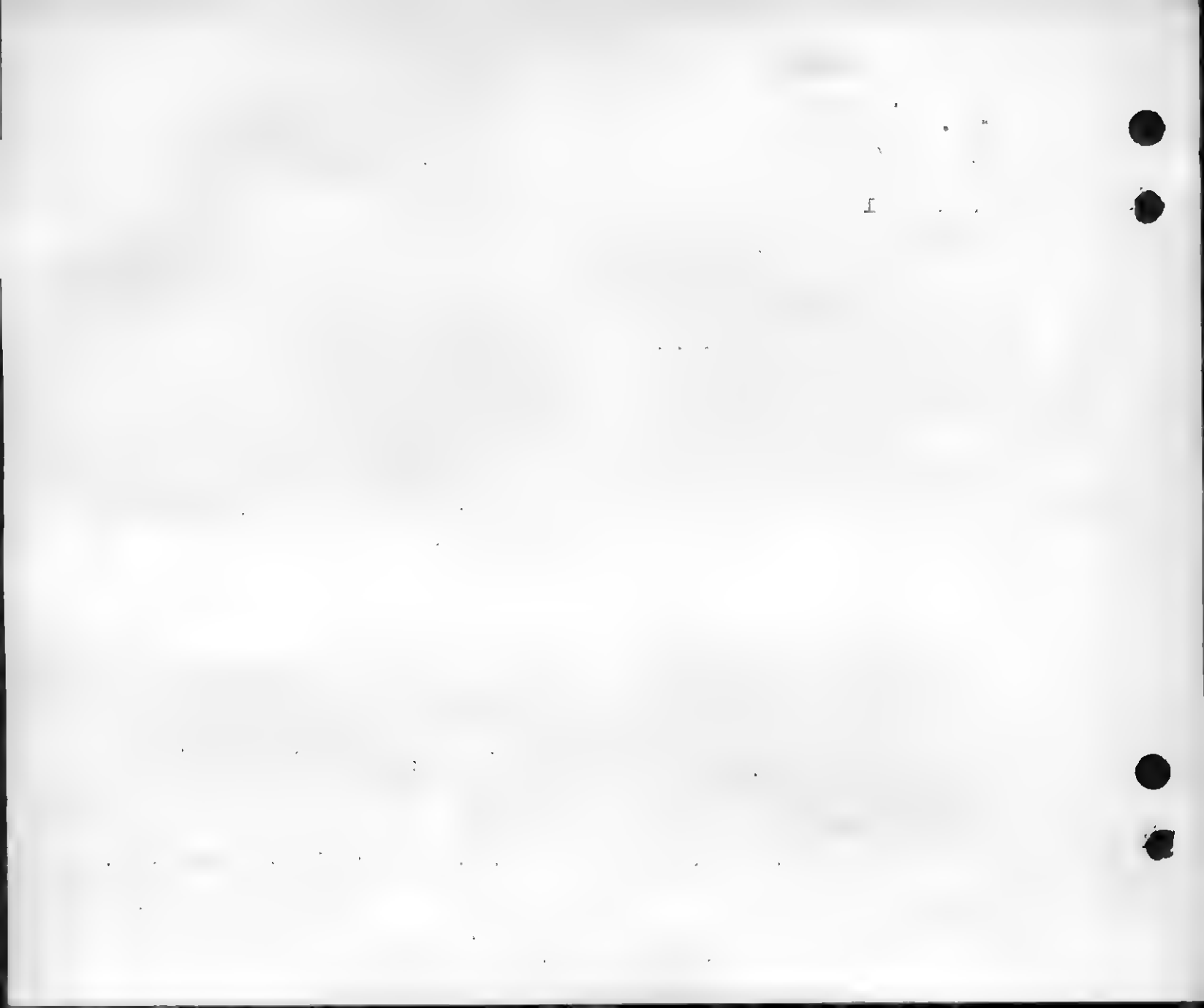
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02093

2122

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Georgia c. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS Box 417			
3. NAME OF DECEASED (Type or print) First Flora Middle Nell Last MAYSON				4. DATE OF DEATH Month February Day 11 Year 19 61			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-15-22	
9. AGE (in years last birthday) 39 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - - -			
11. BIRTHPLACE (State or foreign country) Georgia				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Joe BENFIEL				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			
17. INFORMANT (H) Efford MAYSON CS2 USN, Same as #2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO Instantaneous Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Cause Unknown DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a m. p m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that he (this hospital) attended the deceased from Feb. 1 19 61 to Feb. 11 19 61 that he (we) last saw the deceased alive on Feb. 11 19 61 , and that death occurred at 7:20 PM M, from the causes and on the date stated above.							
22a. SIGNATURE William P. Baker				22b. DATE 2-12-61			
22c. PHYSICIAN'S NAME (Type) William P. BAKER, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 2-13-61				23b. DATE THEREOF 2-13-61			
23c. NAME OF CEMETERY OR CREMATORY Level Grove Cemetery				23d. LOCATION (City, town, or county) (State) Cornelia Georgia			
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler				25a. REC'D BY REGISTRAR DATE FEB 14 '61			
25b. REGISTRAR'S SIGNATURE Charles L. Howard							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be read by a spiritual or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is not reported, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME
5M 7/59

1/12

(M)

(I)

MEDICAL CERTIFICATION

<div> <div> <div>1/12</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is not reported, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.</div> <div>TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.</div> </div> </div> <div> <div> <div>VS. A15ME</div> <div>5M 7/59</div> </div> <div> <div>1/12</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>(M)</div> <div>(I)</div> </div> <div> <div>MEDICAL CERTIFICATION</div> </div> </div> <div> <div> <div> <div>2123</div> <div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> <div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>c. LENGTH OF STAY IN 1b</div> <div>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</div> </div> <div> <div>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</div> <div>a. STATE</div> <div>b. COUNTY</div> <div>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>d. STREET ADDRESS</div> <div>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div> </div> <div> <div> <div>3. NAME OF DECEASED (Type or print)</div> <div>4. DATE OF DEATH</div> <div>5. SEX</div> <div>6. COLOR OR RACE</div> <div>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></div> <div>8. DATE OF BIRTH</div> <div>9. AGE (In years last birthday)</div> <div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div>11. BIRTHPLACE (State or foreign country)</div> <div>12. CITIZEN OF WHAT COUNTRY?</div> </div> <div> <div>13. FATHER'S NAME</div> <div>14. MOTHER'S MAIDEN NAME</div> <div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)</div> <div>16. SOCIAL SECURITY NO.</div> <div>17. INFORMANT</div> </div> </div> <div> <div> <div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>DUE TO (b)</div> <div>DUE TO (c)</div> <div>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div> <div>INTERVAL BETWEEN ONSET AND DEATH</div> <div>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div> </div> <div> <div>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/></div> <div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</div> <div>20c. TIME OF INJURY Month, Day, Year</div> <div>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/></div> <div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> <div>20f. (City or town) (County) (State)</div> </div> </div> <div> <div> <div>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></div> <div>CHIEF MEDICAL EXAMINER <input type="checkbox"/></div> <div>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></div> <div>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></div> <div>DATE SIGNED</div> </div> <div> <div> <div>ACTUAL SIGNATURE</div> <div>NAME (Type)</div> </div> <div> <div>22a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>22b. DATE THEREOF</div> <div>22c. NAME OF CEMETERY OR CREMATORY</div> <div>22d. LOCATION (City, town, or country) (State)</div> </div> </div> <div> <div> <div>23. FUNERAL DIRECTOR</div> <div>ADDRESS</div> </div> <div> <div>24a. REC'D BY REGISTRAR</div> <div>24b. REGISTRAR'S SIGNATURE</div> </div> </div> </div> </div>											
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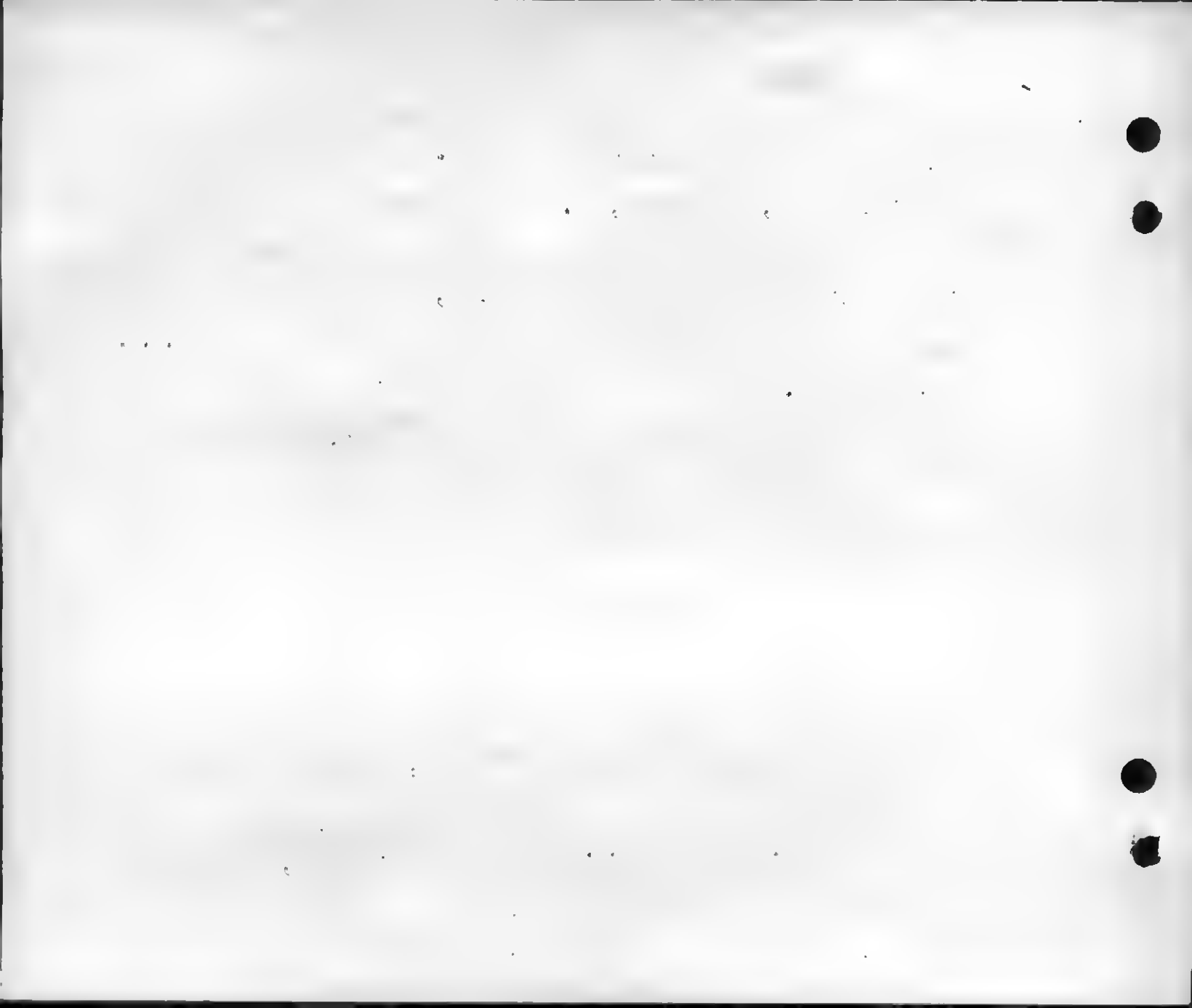


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2124

02111

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Res. before admission) a. STATE South Carolina b. COUNTY Greenville	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenville	
c. LENGTH OF STAY IN 1b 13 Days		d. STREET ADDRESS 400 Rockmont Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Karen Middle Elizabeth Last McCall		4. DATE OF DEATH Month February Day 4 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1955
9. AGE (In years last birthday) 5 yrs		10. IF UNDER 1 YEAR Months 5 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alvin McCall Jr.		14. MOTHER'S MAIDEN NAME Wanda Ervin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Records		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrhythmia or Arrest 289.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hyperkalemia (c) Cystinosis with Renal Involvement		INTERVAL BETWEEN ONSET AND DEATH minutes months 5 yrs 10 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 22, 1961 , to February 4, 1961 , that (I) (we) last saw the deceased alive on February 4, 1961 , and that death occurred at 4:45 AM from the causes and on the date stated above.			
22a. SIGNATURE Dr. Daniel V. Kimberg		22b. DATE SIGNED Feb 4, 1961	
22c. PHYSICIAN'S NAME (Type) Daniel V. Kimberg M.D.		22d. ADDRESS The Clinical Center National Institutes Of Health Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 2-4-61		23b. DATE THEREOF 2-4-61	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn Mem. Park		23d. LOCATION (City, town, or county) (State) Greenville, South Car.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR DATE 8 '61	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deaths are necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

2125
MONTGOMERY STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>601 Broadwood Dr</u>		d. STREET ADDRESS <u>1601 Broadwood Dr</u>	
3. NAME OF DECEASED (Type or print) <u>Russell Rutland McGuire</u>		4. DATE OF DEATH <u>Feb 19 1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> D.VORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-16-06</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>U.S.C.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Public relations</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Marion H. McGuire</u>		14. MOTHER'S MAIDEN NAME <u>Walter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>177-26-3808</u>	
17. INFORMANT <u>Grace McGuire (wife)</u>		Address <u>Ilm 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>+20.1</u> DUE TO <u>Cornary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. (c) <u></u> DUE TO <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Y. or Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschaw</u>		M.D. <u></u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschaw</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>2/19/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Metairie</u>		22d. LOCATION (City, town, or country) (State) <u>New Orleans La.</u>	
23. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		ADDRESS <u>1501 E. Montg. Ave., Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>FEB 23 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION



1.
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is reported, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
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VS. A15ME
5M 7/59

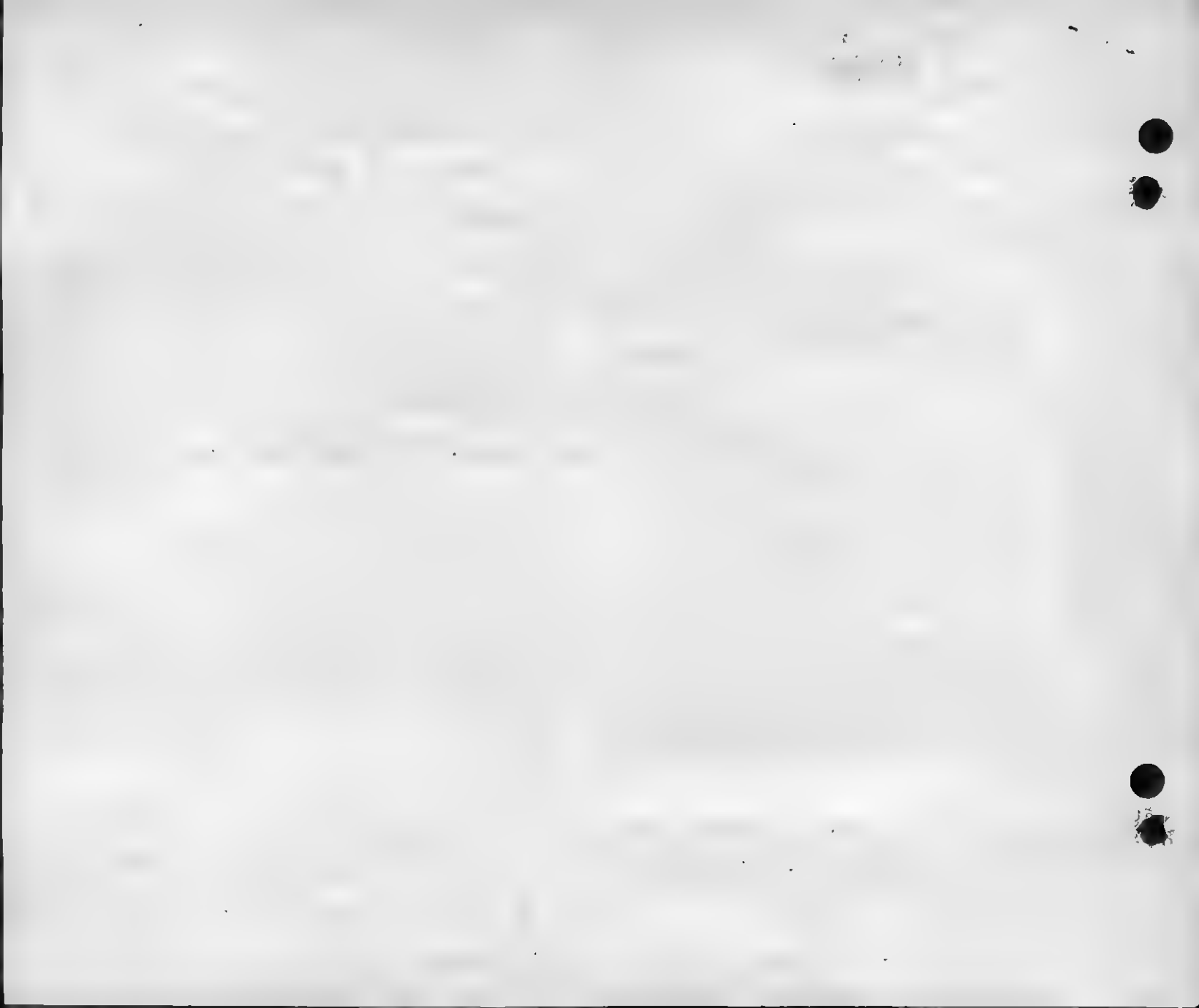
3
MONTGOMERY STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2126

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

021-13

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) West Chevy Chase		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) West Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4901 Crescent Street		d. STREET ADDRESS 4901 Crescent Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert Taylor		4. DATE OF DEATH February 13 19 61		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 8/5/1871	
9. AGE (in years) IF UNDER 1 YEAR IF UNDER 24 HRS. lest birthday) Months Days Hours Min. 89 yrs. 6 8		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Carpenter	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Levi McMullen	
14. MOTHER'S MAIDEN NAME Candada Taylor		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT Edith V. Robey-daughter-same 2d	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)		DATE SIGNED 2/13/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/15/61		22c. NAME OF CEMETERY OR CREMATORY Nat. Memorial Park	
22d. LOCATION (City, town, or county) Falls Church, Virginia		(State)			
23. FUNERAL DIRECTOR Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR FEB 15 '61	
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>					



2127

CERTIFICATE OF DEATH

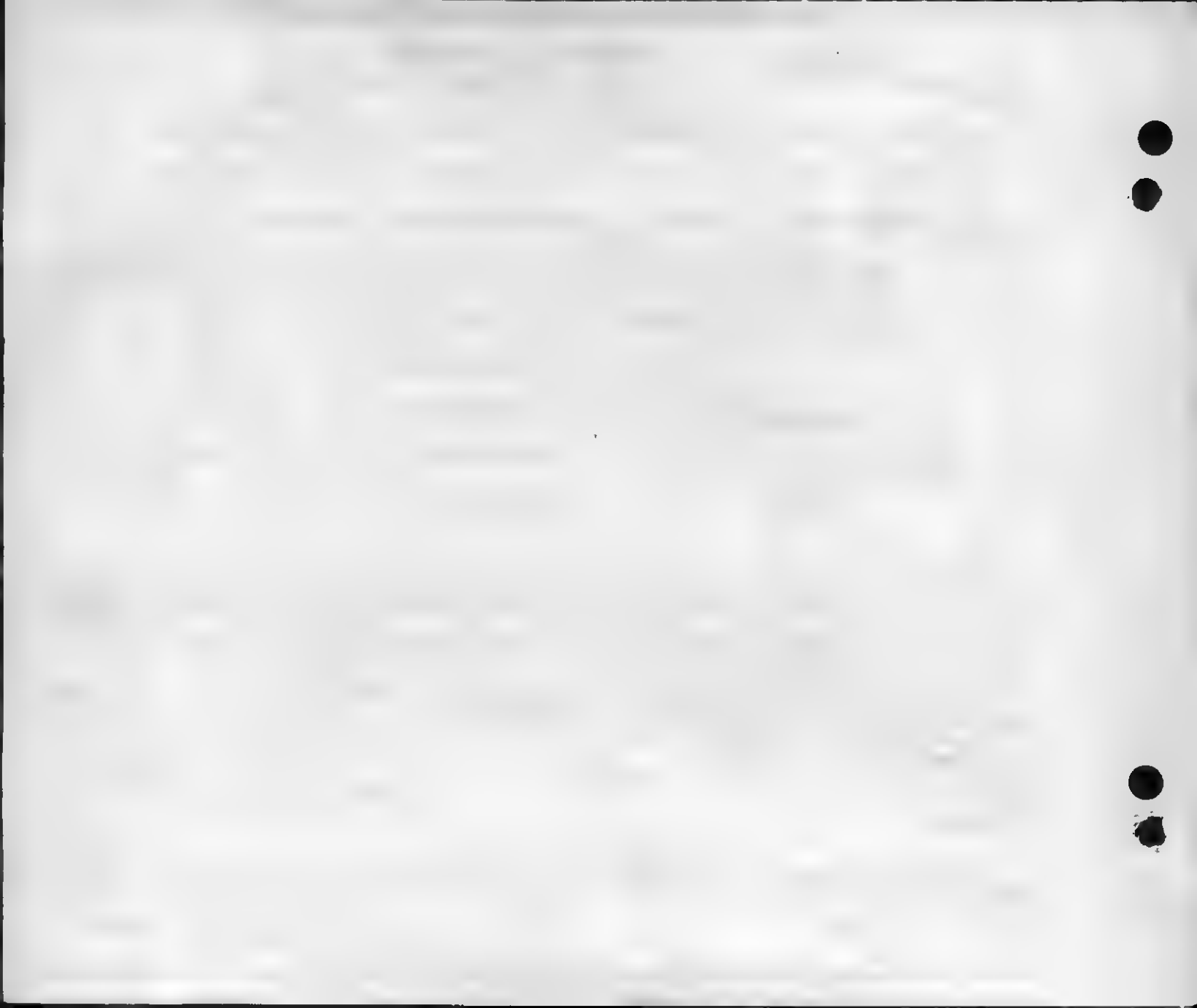
Reg. Dist. No. 021

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARLEA NURSING HOME</u>		d. STREET ADDRESS <u>948 N. MONTGOMERY DR</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LOUISE A. MELIA</u>		4. DATE OF DEATH Month Day Year <u>2 12 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 3, 1898</u>
9. AGE (In years last birthday) <u>62</u> yrs		IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Receptionist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone Co</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va. H. D. 2</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES SAWFORD</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE WALSH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>518-07-6302</u>	
17. INFORMANT <u>Louise A. Melia</u>		Address <u>Rockville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Cerebral Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>12 hrs</u> <u>@ 5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Leukitis & coronary arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/11/1960</u> to <u>2/12/1961</u> that I last saw the deceased alive on <u>2/12/1961</u> , and that death occurred at <u>8:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stephen N. Jones</u> M.D.		ADDRESS (Street, city or town, state) <u>Rockville, Md</u>	
DATE SIGNED <u>2/12/61</u>			
PHYSICIAN'S NAME (Type) <u>STEPHEN N. JONES</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>FEB 14, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CATHOLIC HAVEN</u>		22d. LOCATION (City, town, or county) (State) <u>WILKINSON MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Taltaville</u> ADDRESS <u>3603 14th St NW</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 14 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2128 CERTIFICATE OF DEATH 02195

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 2 1/2 hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase, d. STREET ADDRESS 4610 Davidson Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph First Meyerson Middle Meyerson Last 5 SEX Male 6 COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8 DATE OF BIRTH 2/16/86 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH Feb. 27 19 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 10b. KIND OF BUSINESS OR INDUSTRY Stock Broker 11. BIRTHPLACE (County & State, or foreign country) New York 12. CITIZEN OF WHAT COUNTRY? Minnie - - -		13. FATHER'S NAME Nathan Meyerson 14. MOTHER'S MAIDEN NAME Martha V. (wife) Address same as above	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no 16. SOCIAL SECURITY NO. 200-2 17. INFORMANT Martha V. (wife) Address same as above		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal hemorrhage from malignant lymphoma 200-2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 11, 1961 to Feb 27, 1961 , that (I) was last saw the deceased alive on Feb 27, 1961 , and that death occurred at 9:30 M, from the causes and on the date stated above.			
22a. SIGNATURE Dr Joseph Kendrick M.D.		22b. DATE SIGNED 2/27/61	
22c. PHYSICIAN'S NAME (Type) DR JOSEPH KENDRICK		22d. ADDRESS 6450 Wisconsin Ave, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-2-1961	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Suitland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Souleir Sons ADDRESS 1750 Penn Ave		25a. REC'D BY REGISTRAR MAR 1 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Evans	

1911



THE UNIVERSITY OF CHICAGO



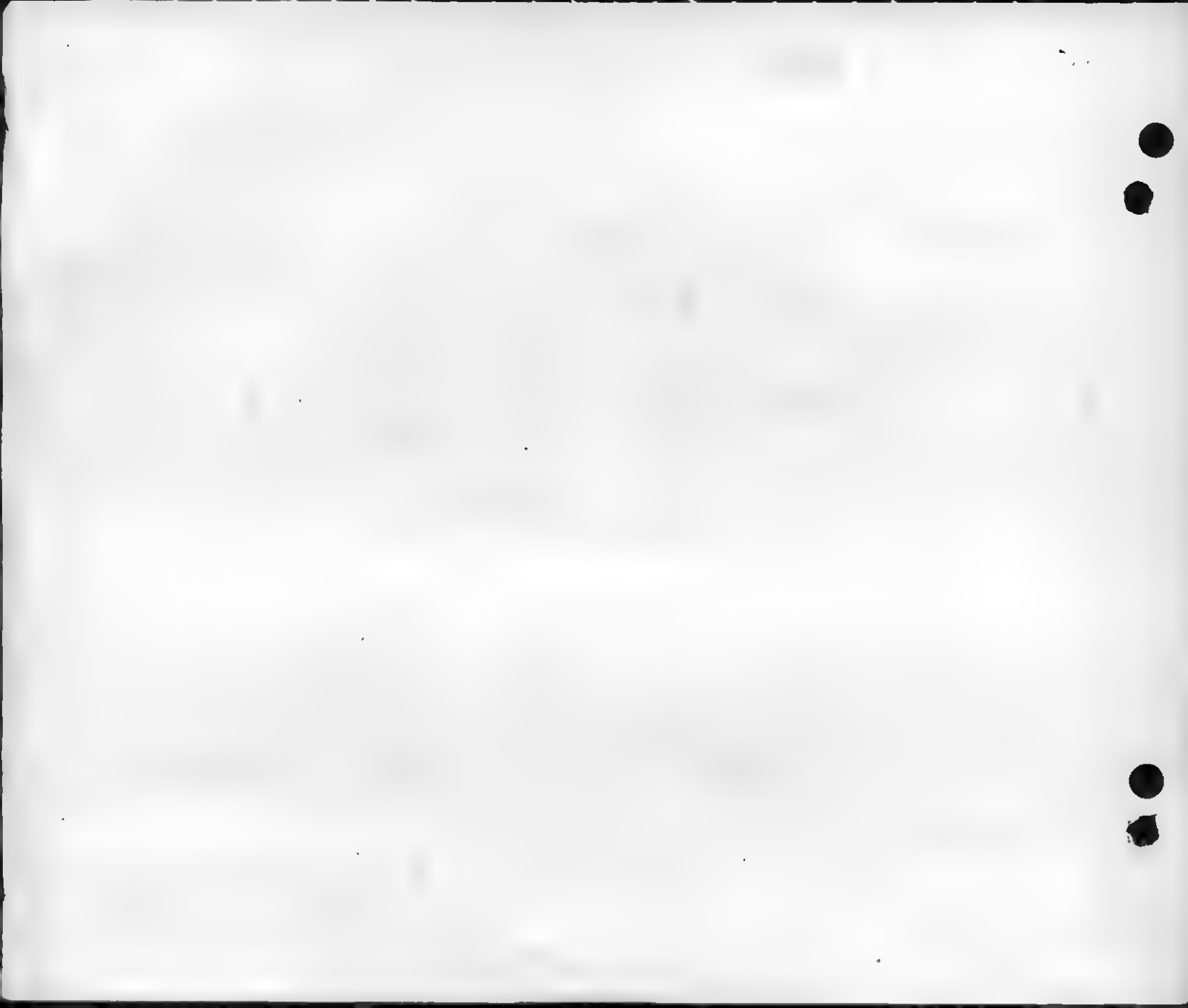


THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

2129

02190

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 yrs. 2 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor San.</u>		e. STREET ADDRESS <u>3542 Paymoor Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>V.</u> Last <u>Michael</u>		4. DATE OF DEATH Month <u>February</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/21/65</u>
9. AGE (In years last birthday) <u>95</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>27</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Lithgow</u>		14. MOTHER'S MAIDEN NAME <u>Florence J. Pettigrew</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Brotherhood-daughter-same 2d</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month <u></u> Day <u></u> Year <u>19</u> Hour <u></u> o. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>10/1/58</u> to <u>2/18/61</u> , that (I) (we) saw the deceased alive on <u>2/18/61</u> and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas S. Sappington</u> M.D.		22b. DATE SIGNED <u>2/18/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS S. SAPPINGTON</u>		22d. ADDRESS <u>1025 CONNECTICUT AVE N.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/21/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Reform Cemetery</u>		23d. LOCATION (City, town, or county) <u>Middletown, Maryland</u> (State) <u></u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Hines</u> DATE <u>FEB 21 '61</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u></u>	

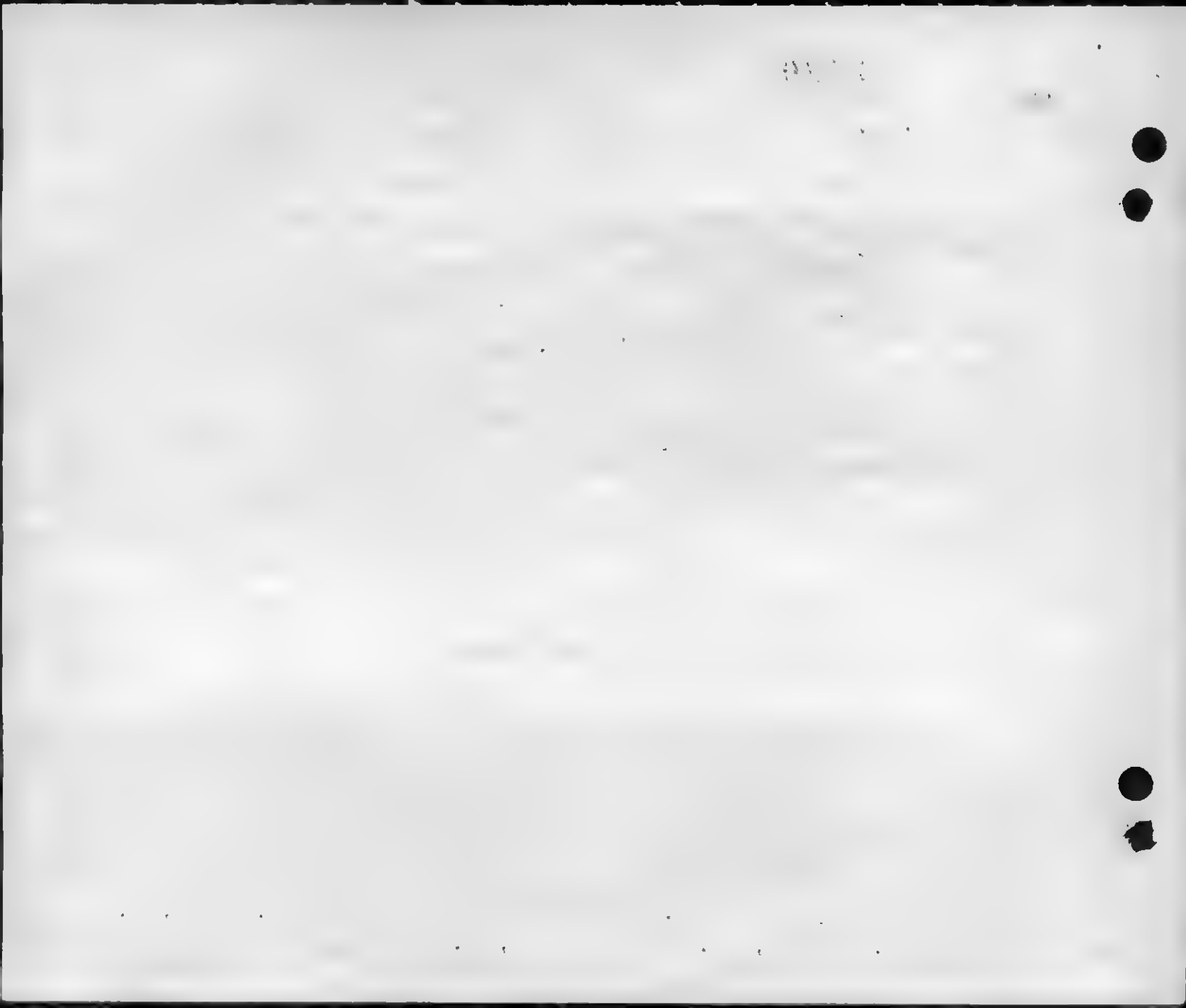


TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
M
2130
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
02197

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b. <u>22 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanatorium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1804 University Blvd. East</u>	
3. NAME OF DECEASED (Type or print) <u>MAUDE F. CARRE</u> 4. DATE OF DEATH <u>February 27 1961</u>		5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>September 24, 1890</u> 8. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife Clerk</u> 11. BIRTHPLACE (County & State or foreign country) <u>West Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Mr. Elmer E. Haney</u> 14. MOTHER'S MAIDEN NAME <u>Emma Hill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>162-14-5455</u> 17. INFORMATION <u>Washington Sanatorium and Hospital Records</u>		Address <u>7600 Carroll Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Carcinoma of Gallbladder</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>2 mos.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>		20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 15</u> , 19 <u>61</u> , to <u>Feb 26</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Feb 26</u> , 19 <u>61</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>Lysle Williams</u> M.D. 22b. DATE SIGNED <u>2/27/61</u> 22c. PHYSICIAN'S NAME (Type) <u>Lysle Williams</u> 22d. ADDRESS <u>8700 Colosville Rd Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>3/1/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u> 23d. LOCATION (City, town or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u> 25a. REC'D BY REGISTRAR <u>DATE MAR 6 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause of death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02198

2131

1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b D.C.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanatorium

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park
d. STREET ADDRESS 7118 Maple Ave

3. NAME OF DECEASED (Type or print) David First NAK MIEDZYNSKI Middle Last
4. DATE OF DEATH Feb 15 1961 Month Day Year

5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED ☒ NEVER MARRIED ☐ B. DATE OF BIRTH Aug 9 1919 9. AGE (In years last birthday) 41 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT 10b. KIND OF BUSINESS OR INDUSTRY GROCERY 11. BIRTHPLACE (State or foreign country) Poland 12. CITIZEN OF WHAT COUNTRY? ISRAELI

13. FATHER'S NAME MOSES MIEDZYNSKI 14. MOTHER'S MAIDEN NAME TUBA WEINKRANZ 15. WAS DECEASED EVER IN U.S. (Yes, no, or unknown) NO (If yes give year or dates of service) 1578-56-0900 MR ELY WEINKRANZ 7125 Maple Ave

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) 5.1 (c) sudden
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 2-16-61 20d. INJURY OCCURRED While ☐ Not While ☐ at work at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschert M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPTLY MEDICAL EXAMINER ☒ DATE SIGNED 2-15-61
EXAMINER'S NAME (Type) FRANK J. Broschert Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 2-16-61 22c. NAME OF CEMETERY OR CREMATORY MT. LEBANON CEMETERY 22d. LOCATION (City, town, or country) (State) HYATTSVILLE MD

23. FUNERAL DIRECTOR B Ganyanaky & Sons ADDRESS 3501-14th St NW 24a. REC'D BY REGISTRAR FEB 20 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

MEDICAL CERTIFICATION

L. L. L.

Abstract

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

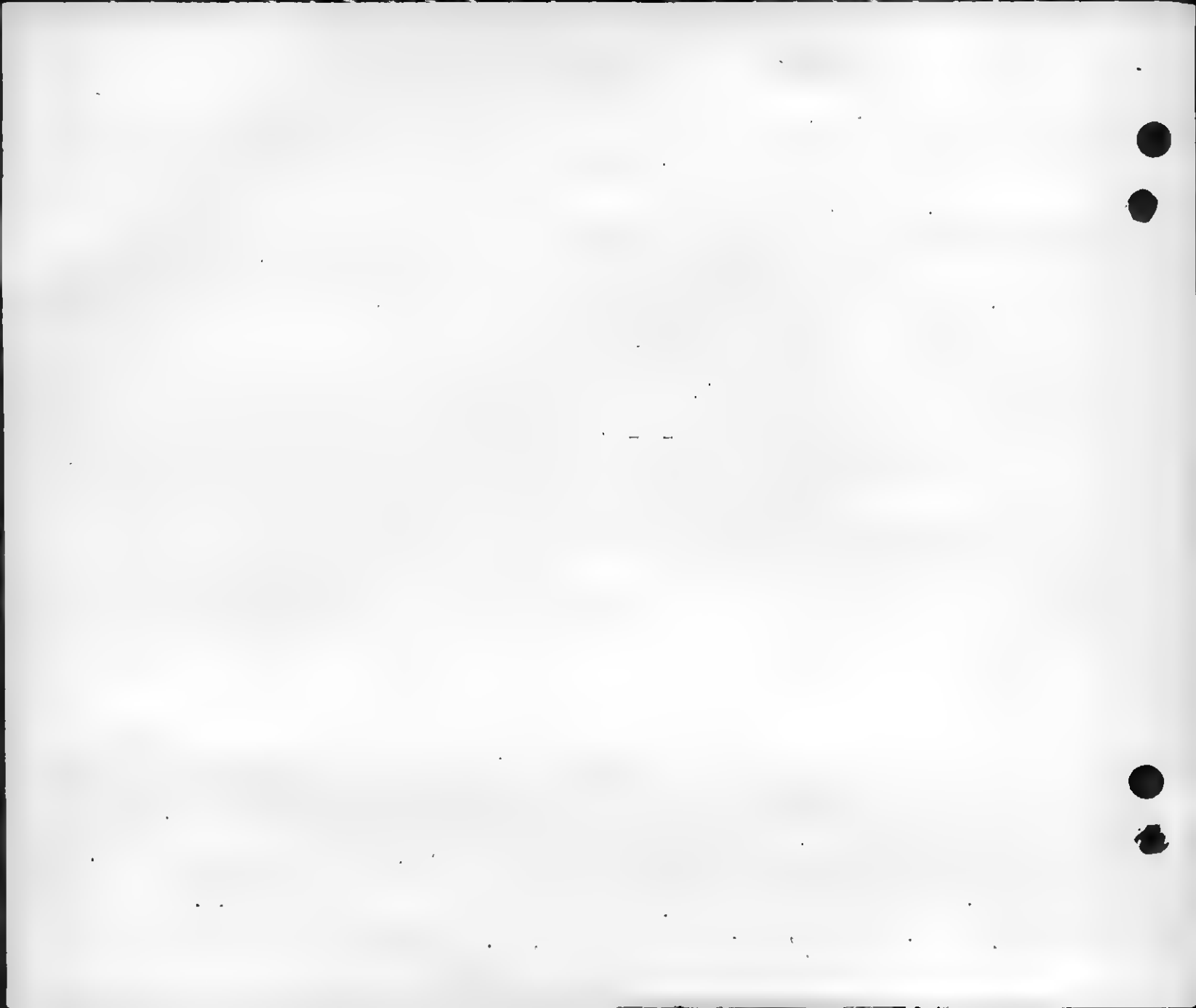
2132

02169

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>15 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10410 Clinton AVENUE</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
f. STREET ADDRESS <u>10410 Clinton AVENUE</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Raymond</u> Last <u>Mills</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>11</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 22 1888</u>	
9. AGE (In years last birthday) <u>72</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lithographer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>		11. BIRTHPLACE (State or foreign country) <u>Dist. of Columbia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>William H. Mills</u>				14. MOTHER'S MAIDEN NAME <u>Amy H. Henninger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>x 577-05-2744</u>		17. INFORMANT <u>Mrs Clara F. Mills</u> Address <u>- Same Address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 1/2 yrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 14, 1958</u> to <u>Feb 11, 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb 11 1961</u> , and that death occurred at <u>6:58 PM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>John Lawrence Awery</u>				22b. DATE SIGNED <u>Feb 11 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>John Lawrence Awery</u>				22d. ADDRESS <u>10110 Georgia Ave., Silver Spring, Md.</u>			
23a. BURIAL PERMIT NO. <u> </u>				23b. DATE THEREOF <u>2/15/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>	
23d. LOCATION (City, town, or county) <u>WASHINGTON, D.C.</u>				23e. (State) <u> </u>			
24. INTERPRETER'S SIGNATURE <u>Raymond A. Giska</u>				24a. ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 16 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiana</u>							

X

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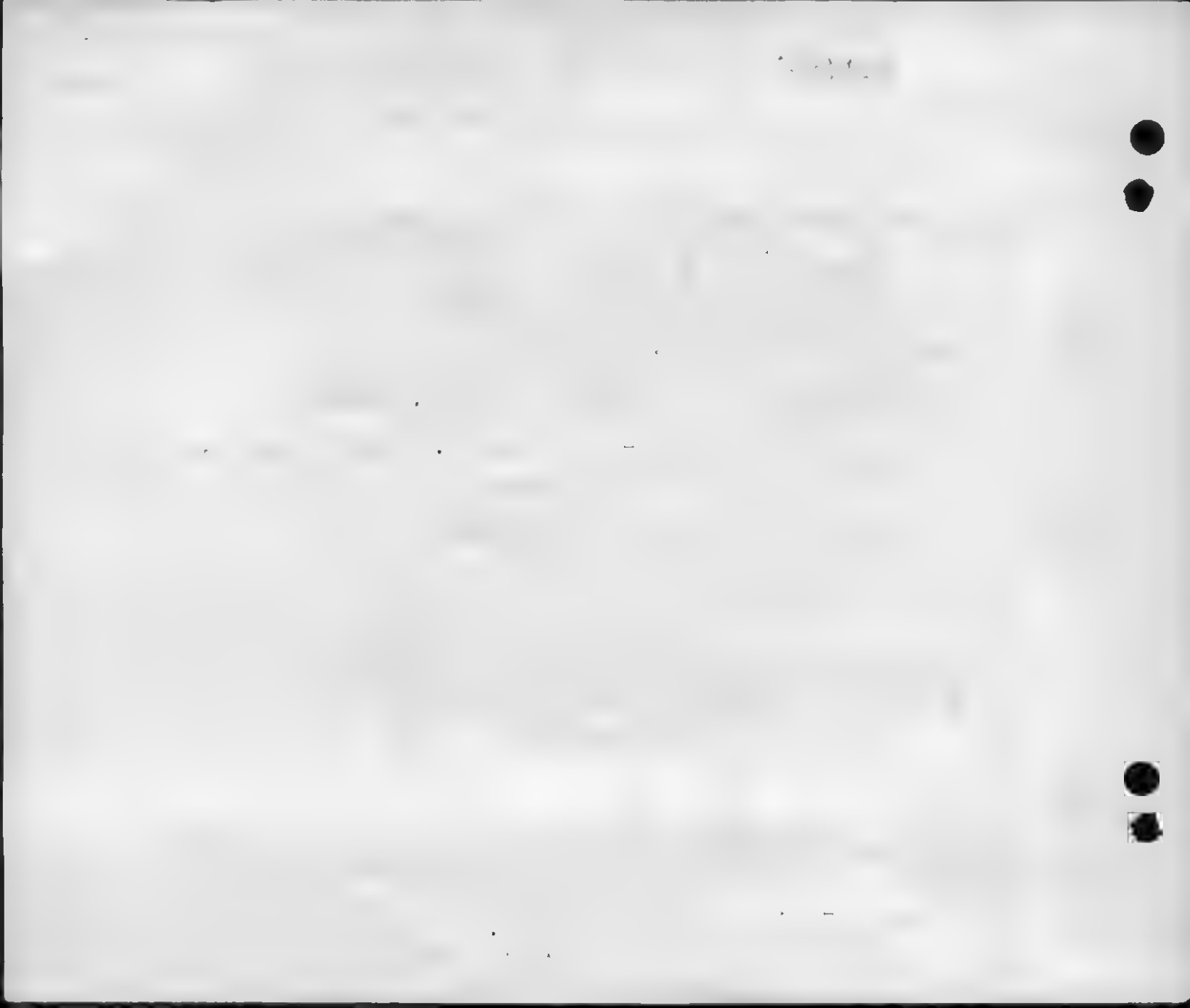
2133

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

021

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Connecticut	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		b. COUNTY New Haven	
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2244 Washington Avenue		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waterbury	
d. STREET ADDRESS 27 Coe St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Francis MOFFETT		4. DATE OF DEATH Month February Day 19 Year 1961	
5. SEX Male		6. DATE OF BIRTH 3 Dec 1926	
6. COLOR OR RACE Caucasian		7. AGE (In years last birthday) 34 yrs.	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		IF UNDER 1 YEAR: Months 34 Days 0 Hours 0 Mins. 0	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		9. CITIZEN OF WHAT COUNTRY? USA	
10. FATHER'S NAME Bernard V Moffett		11. BIRTHPLACE (State or foreign country) Washington, D C	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) yes		13. MOTHER'S MAIDEN NAME Mary I. Garren	
14. SOCIAL SECURITY NO. 578-26-8005		15. INFORMANT Margaret A. Moffett	
16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction (b) Arteriosclerotic heart disease (c) Due to PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) Contributing to death		17. INTERVAL BETWEEN ONSET AND DEATH 27 Coe St, Waterbury, Conn	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 20 February 1961	
EXAMINER'S NAME (Type) FRANK J. BROSCART		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2-23-61	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or country) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR J. J. Collins		24a. REC'D BY REGISTRAR FEB 21 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

VS. A15MB
5M 7/59



2134

CERTIFICATE OF DEATH

Reg. Dist. No. 02111

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>57</u> d. STREET ADDRESS <u>Emory Grove Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>B</u> Last <u>MOODY</u>		4. DATE OF DEATH February 15 1961	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/15/61</u>
9. AGE (In years, last birthday) <u>8</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>15</u> Hours <u>15</u> Min <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS MOODY</u>		14. MOTHER'S MAIDEN NAME <u>GLORIA EXCHILSEN WATERS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
INFORMANT <u>MOTHER</u>		Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal atelectasis</u> (b) <u>—</u> (c) <u>—</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>762.0</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/15</u> , 19 <u>61</u> , to <u>2/15</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>2/15</u> , 19 <u>61</u> , and that death occurred at <u>3:45</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. L. Swensen</u> M.D.		ADDRESS (Street, city or town, state) <u>4740 Branley Blvd CHCH Md</u>	
DATE SIGNED <u>FEB 23 '61</u>		DATE SIGNED <u>Arthur S. Frank</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2-16-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Amelia Carter, Administrator</u>		24a. REC'D BY REGISTRAR <u>—</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>		24c. DATE <u>FEB 23 '61</u>	

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TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

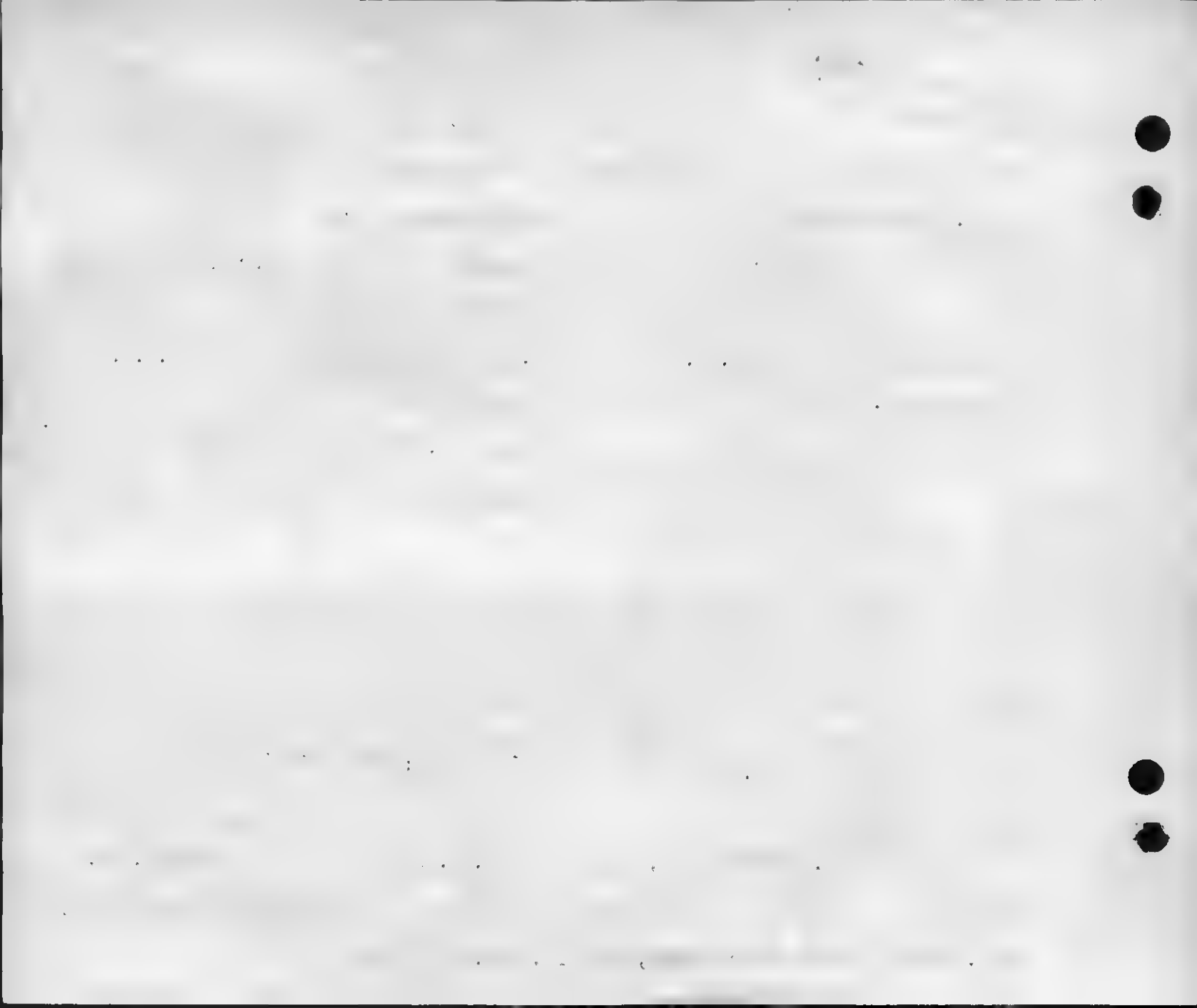
TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed after death. Pages 1 and 2 may be retained by the hospital or attending physician.

2135

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02112

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Pennsylvania b. COUNTY Harrisburg c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3970 Green Street d. STREET ADDRESS 3970 Green Street	
3. NAME OF DECEASED (Type or print) First Middle Last Walter Mann MUMMA		4. DATE OF DEATH Month Day Year February 25 1961	
5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH 11-20-90		9. AGE (In years) IF UNDER 1 YEAR: IF UNDER 24 HRS. last birthday) Months Days Hours Min 70 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Congressman		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
13. FATHER'S NAME Christian N. MUMMA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. (S) Robt. M. Mumma, Pennsboro Manor, Wormleysburg	
17. INFORMANT (S) Robt. M. Mumma, Pennsboro Manor, Wormleysburg		14. MOTHER'S MAIDEN NAME Agnès SHOPE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 Feb. 23 3:30PM 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Harrisburg 20f. (City or town) (County) (State) Harrisburg Harrisburg Pennsylvania			
21. I certify that (X) (this hospital) attended the deceased from Feb. 23 1961 to Feb. 25 1961 , that (X) (we) last saw the deceased alive on Feb. 25 1961 , and that death occurred at 3:30PM M, from the causes and on the date stated above.			
22a. SIGNATURE J. J. CAVANAGH		22b. DATE SIGNED 2-25-61	
22c. PHYSICIAN'S NAME (Type) J. J. CAVANAGH, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-28-61	
23c. NAME OF CEMETERY OR CREMATORY East Harrisburg Cemetery		23d. LOCATION (City, town or county) (State) Harrisburg Harrisburg Pennsylvania	
24. FUNERAL DIRECTOR'S SIGNATURE Jos. Gawler's Sons Funeral Home, 1756 Pa. Ave. NW		25. REC'D BY REGISTRAR FEB 28 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Klaus			



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

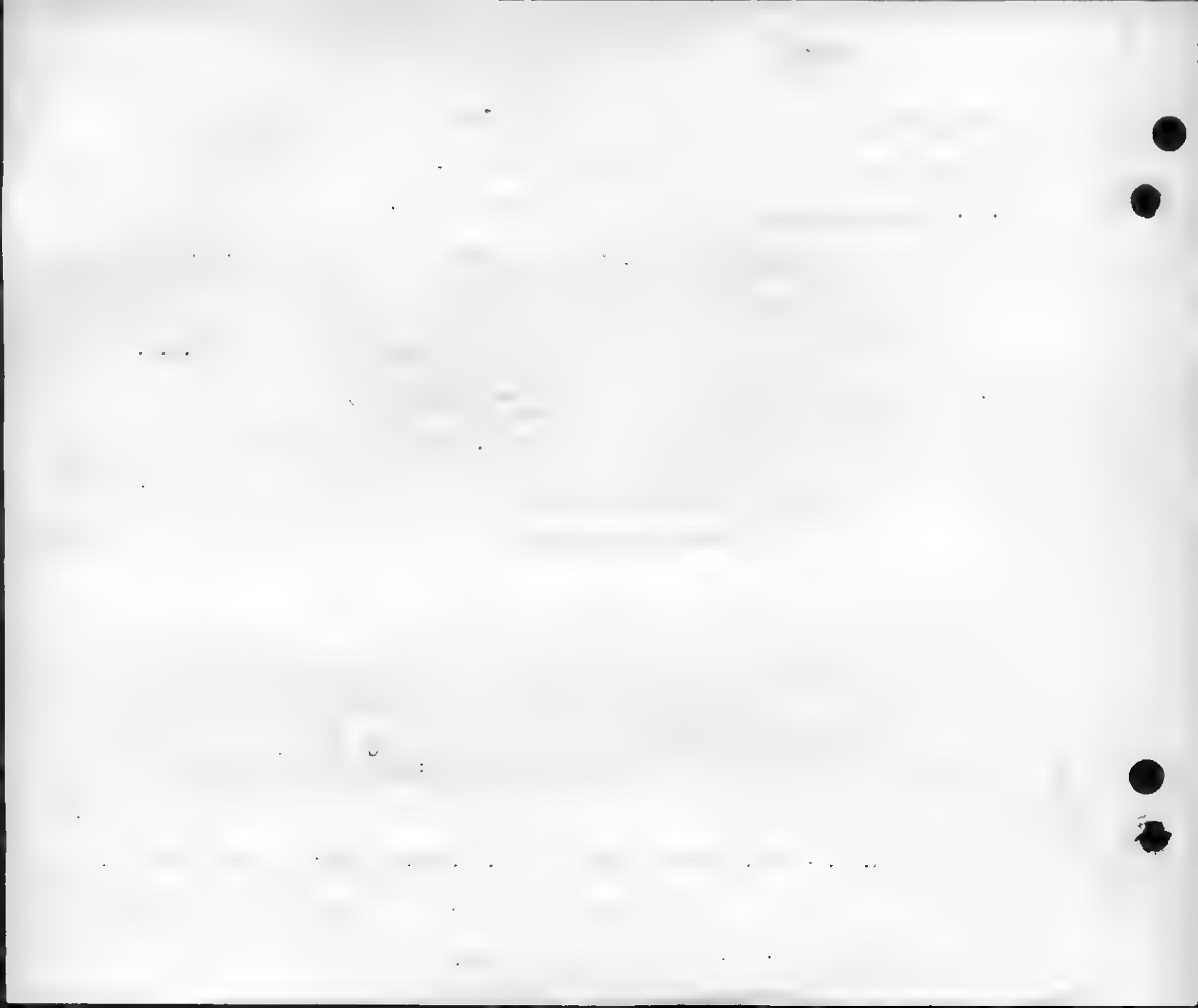
2136

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02113

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland		b. COUNTY a. a.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 171 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS 418 6th Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Olga		Middle Maria		Last NYMAN		4. DATE OF DEATH Month February	
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-29-80	
9. AGE (in years last birthday) 80		10. UNDER 1 YEAR Months 80		11. UNDER 24 HRS Days 80		12. UNDER 24 HRS Hours 80	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Finland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David TENHUNEN		14. MOTHER'S MAIDEN NAME Maria (Unknown)					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. None		17. INFORMANT (S) Benj. Nyman, sae as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Toxemia, generalized DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b): Pemphigus vulgaris DUE TO (c): PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):		INTERVAL BETWEEN ONSET AND DEATH 1 month 10 yrs.				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (u) (this hospital) attended the deceased from August 22, 1960 to Feb. 9, 1961 that (u) (we) last saw the deceased alive on Feb. 9, 1961 , and that death occurred at 3:31 AM from the causes and on the date stated above							
22a. SIGNATURE R. W. Jones		M. D. <input type="checkbox"/>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2-9-61	
22c. PHYSICIAN'S NAME (Type) R. W. JONES, CDR, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-13-61		23c. NAME OF CEMETERY OR CREMATORY Naval Academy Cemetery		23d. LOCATION (City, town, or county) (State) Annapolis Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE B. L. Hopping & Son		ADDRESS B. L. Hopping & Son Funeral Home, Annapolis, Md.		25a. REC'D BY REGISTRAR FEB 10 '61		25b. REGISTRAR'S SIGNATURE ...	

MEDICAL CERTIFICATION



12-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

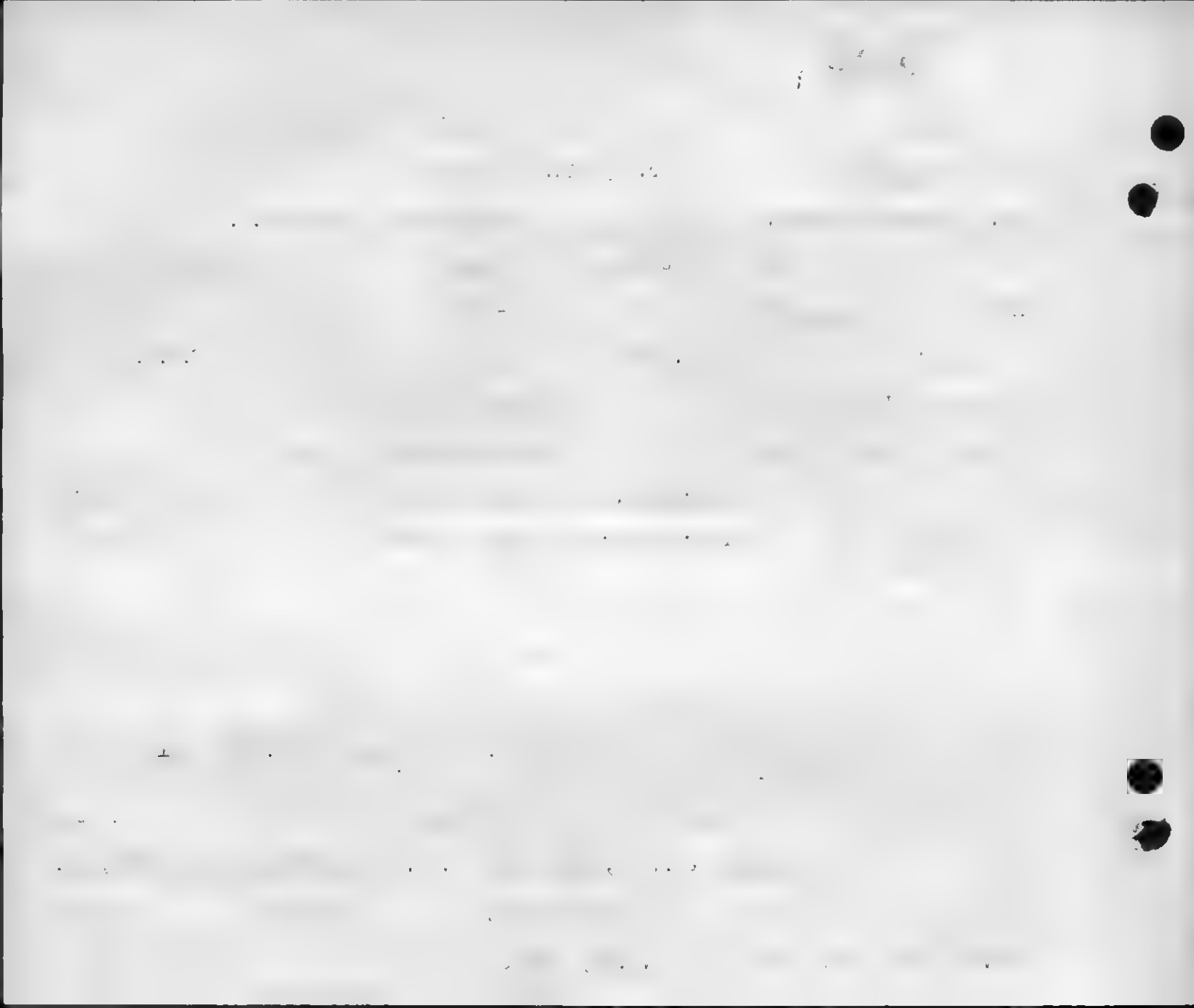
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2137

02114

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>1 hr. 35 min.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital,</u>		2. USUAL RESIDENCE (Where deceased lived, If institutions: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>District of Columbia</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>3801 Benton Street, N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Daniel Joseph O'BRIEN</u>	4. DATE OF DEATH Month <u>February</u> Day <u>20</u> Year <u>1961</u>	9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.) last birthday <u>69</u> yrs. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
5. SEX <u>Male</u> 6. COLOR OR RACE <u>Caucasian</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. BIRTH <u>8-30-91</u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Officer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Nevada</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>William O'BRIEN</u> 14. MOTHER'S MAIDEN NAME <u>Mary MC CARTY</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>1910 to 1953</u> 17. INFORMANT <u>Hospital Records</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infarction, myocardium</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		
20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part I of item 18) <u> </u>		
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> e.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that (I) (NAME) attended the deceased from <u>Feb. 20, 1961</u> to <u>Feb. 20, 1961</u> that (I) (NAME) last saw the deceased alive on <u>Feb. 20, 1961</u> and that death occurred at <u>8:20AM</u> from the causes and on the date stated above.				
22a. SIGNATURE <u>Russell Miller, Jr.</u>		22b. DATE SIGNED <u>2-20-61</u>	22c. PHYSICIAN'S NAME (Type) <u>Russell MILLER, JR., LT, MC, USN</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-23-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City, town or county) <u>Arlington</u>	23e. (State) <u>Virginia</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. DeVol</u>		24b. ADDRESS <u>DeVol Funeral Home, 2224 Wisc. Ave. NW, WashDC</u>	25a. REC'D BY REGISTRAR <u>FEB 21 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hous</u>

MEDICAL CERTIFICATION



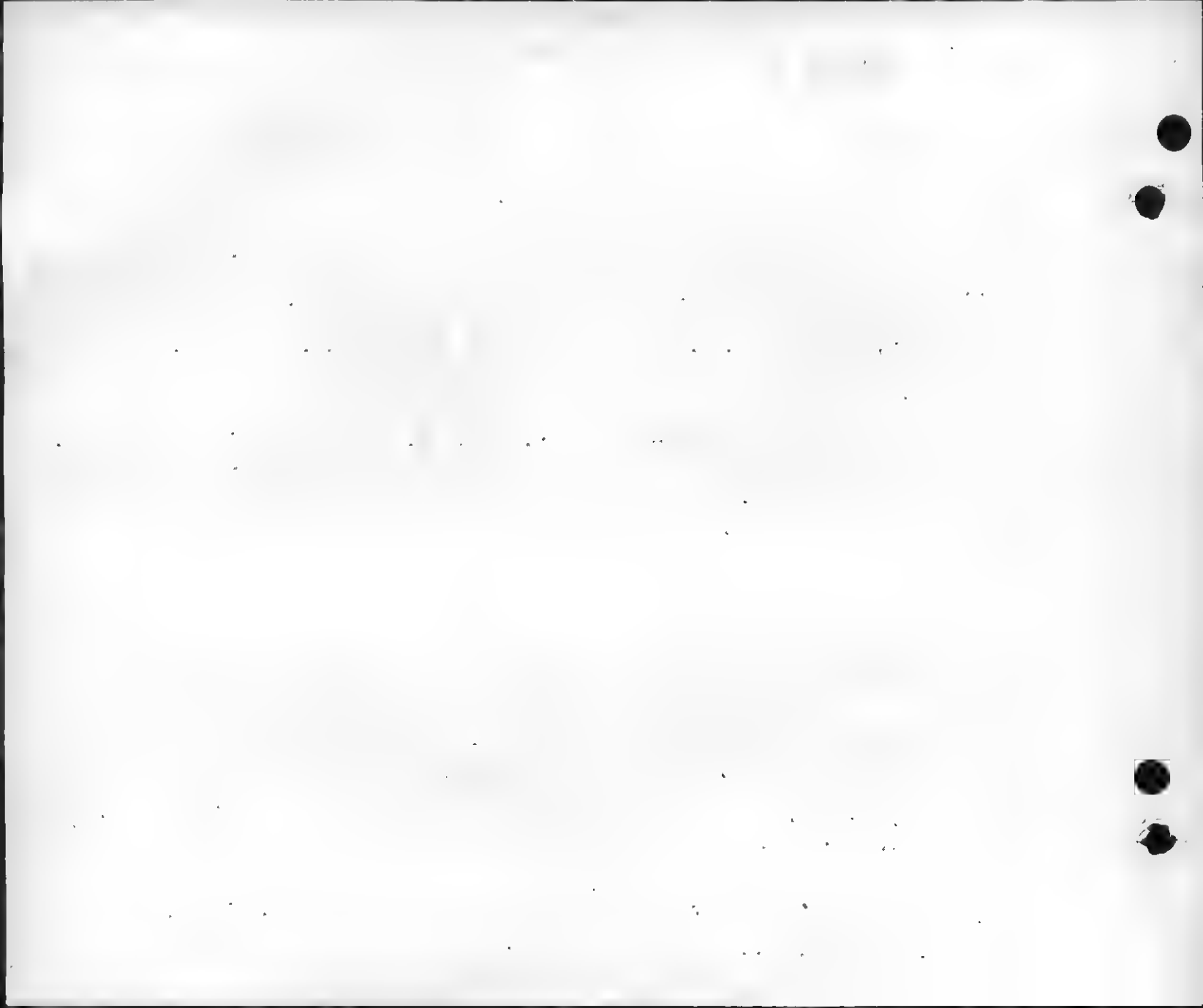
CERTIFICATE OF DEATH

Reg. Dist. No. 02115

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Res. dence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 12 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8403 HARTFORD AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward Francis O'Connor		4. DATE OF DEATH Month FEB. Day 10 Year 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/16/97
9. AGE (In years lost birthday) 63 yrs		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus operator, retired		10b. KIND OF BUSINESS OR INDUSTRY D. C. Transit	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MICHAEL J. O'CONNOR		14. MOTHER'S MAIDEN NAME MARGARET MURPHY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 578-10-7605	
17. INFORMANT Mrs. Ernest F. Knighting, 8403 Hartford Ave.		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Lungs 152.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma Colon DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1950 to 2/10 1961 , that I last saw the deceased alive on 2/8 1961 , and that death occurred at 6:05 AM , from the causes and on the date stated above.			
SIGNATURE W. Fleet Lockett		ADDRESS (Street, city or town, State) 5000 Reno Rd NW	
PHYSICIAN'S NAME (Type) W. FLEET LUCKETT		DATE SIGNED 2/10/61	
22a. BURIAL, CREMAT. OR REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/13/61	
22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC.		24a. REC'D BY REGISTRAR DATE FEB 15 '61	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Carolina S. Kraus	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed 24 hours after death. Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

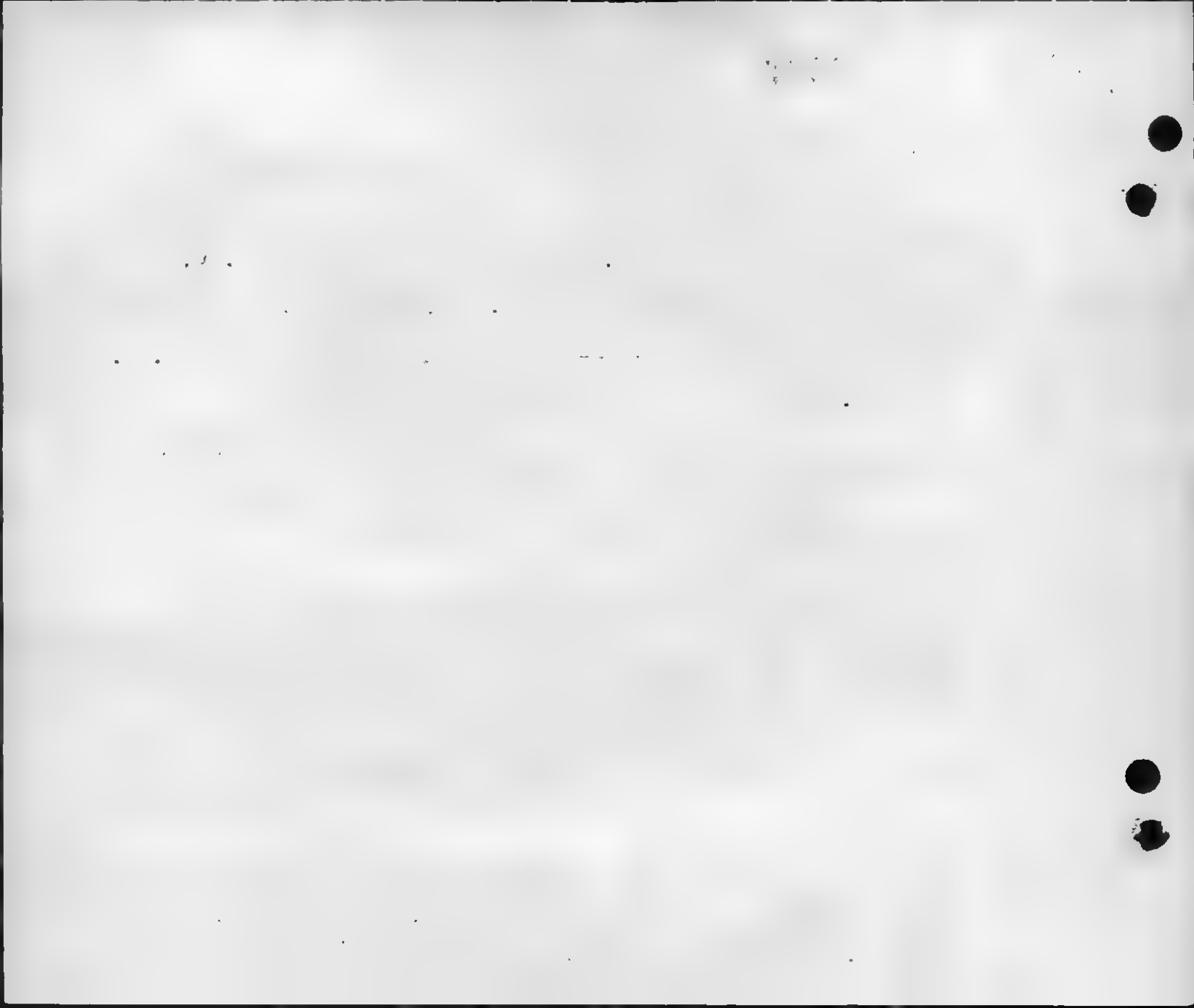
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2139

02116

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fairland</u> c. LENGTH OF STAY IN IL <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fairland Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Colonial Beach</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Colonial Beach</u> d. STREET ADDRESS <u>3X3</u>	
3. NAME OF DECEASED (Type or print) <u>BARBARA W. OERTEL</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>9</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> D. VORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 22, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>	
13. FATHER'S NAME <u>George W. Iste</u>		14. MOTHER'S MAIDEN NAME <u>Sally Mae Westland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Charles Oertel, Bethesda, Md.</u>		Address <u>step-grandson</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUETO <u>Adeno Ca Rectum -</u> Conditions, if any, which gave rise to immediate cause (b) <u>Rectum -</u> (c) <u>Rectum -</u> cause last. <u>Rectum -</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 8th 1961</u> to <u>Feb 9th 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb 8th 1961</u> , and that death occurred at <u>6:45 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert Kramer</u>		22b. DATE SIGNED <u>Feb 9th 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT KRAMER</u>		22d. ADDRESS <u>1703 EAST-WEST Highway SS. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/13/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>Bethesda, Maryland</u>	
25b. REGISTRAR'S SIGNATURE <u>Feb 15 '61</u>		25c. DATE <u>Feb 15 '61</u>	



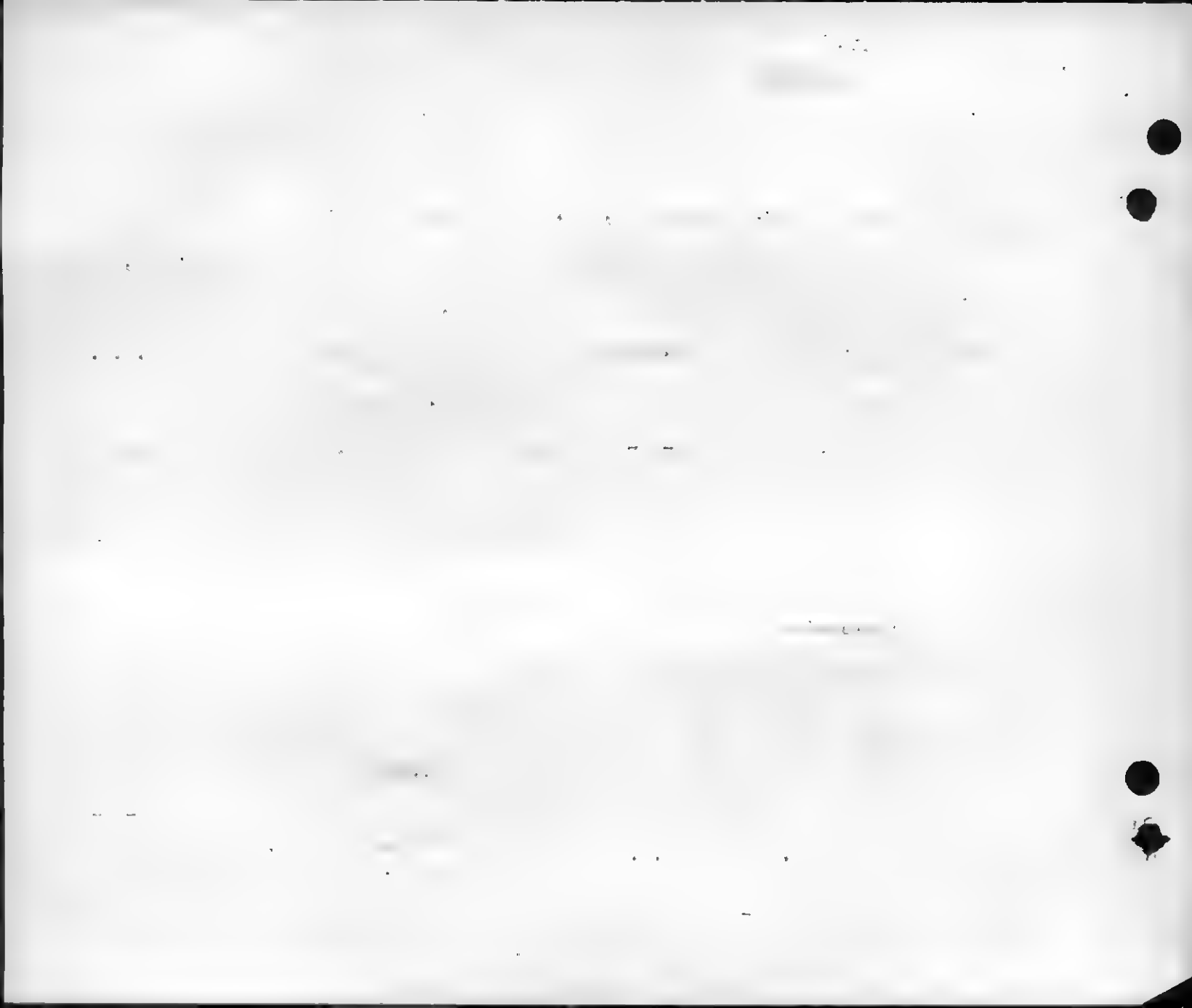
1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02117

2140

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 112 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia		b. COUNTY Charleston		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 811 Smith Street		4. DATE OF DEATH First Middle Last Louis Ralph Olian		Month Day Year February 16, 19 61		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 19, 1922		9. AGE (In years last birthday) 38 yrs		F UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS <input type="checkbox"/>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Gayton Olian		14. MOTHER'S MAIDEN NAME Mary L. Olian		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes Korean		16. SOCIAL SECURITY NO 236-22-6196	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myelogenous Leukemia DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 1 Week 5 Months		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paraplegia		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October 27, 19 60 to February 16, 19 61 that (I) (we) last saw the deceased alive on February 16, 19 61 , and that death occurred 3:30 AM from the causes and on the date stated above.		22a. SIGNATURE Edward E. Morse		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland		22c. PHYSICIAN'S NAME (Type) EDWARD E. MORSE, M.D.		22d. DATE SIGNED 2-16-61	
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial-transit 2-16-61		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		23d. LOCATION (City, town, or county) (State) Charleston, West Virginia		24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
25a. REC'D BY REGISTRAR DATE FEB 17 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Frank		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE		25e. REGISTRAR'S SIGNATURE		25f. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2141

CERTIFICATE OF DEATH

Items 6, 13 & 14 Film G281 2/23/61 mh

02118

<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>MONTGOMERY</u></p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAROMA PARK</u></p> <p>c. LENGTH OF STAY IN 1b <u>15 days</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hosp.</u></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</p> <p>a. STATE <u>Maryland</u></p> <p>b. COUNTY <u>Prince George's</u></p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u></p> <p>d. STREET ADDRESS <u>7602 22nd Ave.</u></p>	
<p>3. NAME OF DECEASED (Type or print) <u>Margaret Magdalene Patterson</u></p> <p>5. SEX <u>Female</u></p> <p>6. COLOR OR RACE <u>White Amer.</u></p> <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/></p> <p>8. DATE OF BIRTH <u>10-31-82</u></p> <p>9. AGE (In years last birthday) <u>78</u> yrs.</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p> <p>10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u></p> <p>11. BIRTHPLACE (County & State, or foreign country) <u>New York</u></p> <p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>	
<p>13. FATHER'S NAME <u>Joseph Patterson</u></p> <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Mary Gleason</u></p> <p>16. SOCIAL SECURITY NO. <u>Hospital Records</u></p> <p>17. INFORMANT <u>Cerebral Vascular Accident</u></p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e)</p> <p><u>3 x 1 V</u> DUE TO <u>Previous Cerebral Vascular Accident</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO <u>HyperTension</u></p> <p>PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NARROW DISEASE CONDITION GIVEN IN PART I (e) <u>Diabetes Mellitus</u></p>		<p>INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u></p> <p><u>14 days</u></p> <p><u>Unknown</u></p> <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>		<p>20c. TIME OF INJURY Month, Day, Year <u>19</u></p> <p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> <p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from <u>1-18</u>, 19<u>61</u>, to <u>2-2</u>, 19<u>61</u>, that (I) (we) last saw the deceased alive on <u>2-1</u>, 19<u>61</u>, and that death occurred at <u>2:50 PM</u>, from the causes and on the date stated above.</p>			
<p>22a. SIGNATURE <u>Arthur S. Kline</u></p> <p>22c. PHYSICIAN'S NAME (Type)</p>		<p>22b. DATE SIGNED <u>2-2-61</u></p> <p>22d. ADDRESS</p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u></p> <p>23b. DATE THEREOF <u>2/6/61</u></p> <p>23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u></p> <p>23d. LOCATION (City, town or county) (State) <u>WASH. D.C.</u></p>		<p>24. FUNERAL DIRECTOR'S SIGNATURE <u>HARLOW FUNERAL HOME - 3831 - GA. AVE. N.W.</u></p> <p>25a. REC'D BY REGISTRAR <u>FEB 17 '61</u></p> <p>25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u></p>	

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02113

2142

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Park</u> c. LENGTH OF STAY IN 1b <u>8 days</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> f. COUNTY <u>Mont</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>19 SAKOMA PARK</u> d. STREET ADDRESS <u>18303 Haddon Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Julius August Perlbachs</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>12/4/98</u> 9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR Months <u>2</u> Days <u>25</u> IF UNDER 24 HRS. Hours <u>19</u> M'n. <u>61</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>accountant</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Latvia</u> 12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>	
13. FATHER'S NAME <u>Woldemars Perlbachs</u> 14. MOTHER'S MAIDEN NAME <u>Eva Udris</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>pt hospital record.</u> 17. INFORMATION <u>Ac Anterior Myocardial Infarction</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) (a), stating the underlying cause last. <u>Due to</u> DUE TO <u>Ac Anterior Myocardial Infarction</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>2/17</u> <u>1961</u> to <u>2/25</u> <u>1961</u> that (I) (we) last saw the deceased alive on <u>2/25</u> <u>1961</u> and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Charles H. Wolohon</u> 22c. PHYSICIAN'S NAME (Type) <u>Charles H. Wolohon</u>		22b. ADDRESS <u>500 Unwood St. NW, Wash. DC</u> 22d. ADDRESS <u>254 Cornell St. N.W. D.C.</u>	
23a. BURIAL, CREMATION, OR REMOVAL <u>Burial</u> 23b. DATE THEREOF <u>Feb 19-1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u> 23d. LOCATION (City, town or county) <u>Washington DC</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Khand</u> 25a. REC'D BY REGISTRAR <u>FEB 28 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Khand</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 may be retained by the hospital or attending physician.

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
2143			
02120			
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN IL		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10709 Glenwild Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Wilmar Bruun Petersen</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/8/1907</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assistant Chief of Repair-Maritime</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Denmark</u>	
13. FATHER'S NAME <u>Alfred Petersen</u>		14. MOTHER'S MAIDEN NAME <u>Marie Bruun</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>579-05-7073</u>	
17. INFORMANT <u>Mrs. Ragnhild Petersen-Rd.</u>		Address <u>10709 Glenwild S.S. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>coronary atherosclerosis</u> (a), stating the underlying cause last, (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>Feb 25, 1961</u> to <u>Feb 25, 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb 25, 1961</u> , and that death occurred at <u>2:41</u> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>H. F. Kreuzburg</u>		22b. DATE SIGNED <u>2/25/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. F. Kreuzburg</u>		22d. ADDRESS <u>7852 16th St NW Wash DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/28/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Falls Church, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		25a. REC'D BY REGISTRAR <u>FEB 27 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>		25c. ADDRESS <u>2901 14th St., N.W. Washington 9, D.C.</u>	

67221

CERTIFICATE OF DEATH

Reg. Dist. No.

02121

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SANITARIUM & HOSPITAL		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 8735 CARROLL AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle MORRIS Last PLOFF		4. DATE OF DEATH Month February Day 9 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 17, 1908
9. AGE (In years last birthday) 52		10. IF UNDER 1 YEAR Months 4 Days 20 Hours 4 Min 40	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY NEW YORK	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SAMUEL PLOFF		14. MOTHER'S MAIDEN NAME ROSE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown, If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO LOUIS PLOFF	
17. INFORMANT LOUIS PLOFF		Address 719 UNIVERSITY BLVD., S.S., MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis DUE TO (c) 440.1		INTERVAL BETWEEN ONSET AND DEATH 4 yrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9:25 P.M. 24, 1958 to Jan 6, 1961 , that I last saw the deceased alive on Jan 6, 1961 , and that death occurred at 6:19 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Bernard Danzansky		ADDRESS (Street, city or town, state) 915-19th ST. N.W. Wash. D.C.	
PHYSICIAN'S NAME (Type) ISIDORE SALKMAN		DATE SIGNED Wash. D.C. 6-26	
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2-12-61	22c. NAME OF CEMETERY OR CREMATORY UNITED HEBREW CEM.	22d. LOCATION (City, town, or county) (State) BALTIMORE MD
23. FUNERAL DIRECTOR'S SIGNATURE BERNARD DANZANSKY & SONS - 3501-14th ST.		24a. REC'D BY REGISTRAR DATE FEB 14 '61	
24b. REGISTRAR'S SIGNATURE Richard S. K...			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2145

02122

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

c. LENGTH OF STAY IN 1b

5 days

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

md.

b. COUNTY

Prince George

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hyattsville

d. STREET ADDRESS

8107 New Hampshire Ave

10. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

(M)

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington Sanitarium + Hospital

3. NAME OF DECEASED (Type or print)

Alice

Fanny

Pope

4. DATE OF DEATH

Feb.

1

1961

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

4-12-90

9. AGE (In years last birthday)

70 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

SCHOOL own home

11. BIRTHPLACE (County & State, or foreign country)

Mass

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

James H. Wild

14. MOTHER'S MAIDEN NAME

Alice Wardle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

no

16. SOCIAL SECURITY NO

30-16-6304

17. INFORMANT

Hospital Records

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Acute Hepatic failure

583X

DUE TO

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

(b)

Thrombosis Hepatic Vein (Budd-chiaris Syn)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

2 days

2 days.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

Abdominal Hernia - post-operative

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a.m. p.m.

Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Jan 26, 1961, to Feb 1, 1961, that (I) (we) last saw the deceased alive on Feb 1, 1961, and that death occurred at 7:45 AM, from the causes and on the date stated above.

22a. SIGNATURE

Lysle Williams

M.D.

ATTENDING PHYS. ☒

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

FEB 1, 1961

22c. PHYSICIAN'S NAME (Type)

Lysle Williams

22d. ADDRESS

8700 Colesville Rd Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE THEREOF

2/6/61

23c. NAME OF CEMETERY OR CREMATORY

ARLINGTON NAT'L. CEMETERY

23d. LOCATION (City, town or county)

ARLINGTON, VIRGINIA

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Raymond E. Pomphrey, Inc.

ADDRESS

SILVER SPRING, MD.

25a. REC'D BY REGISTRAR

DATE FEB 9 '61

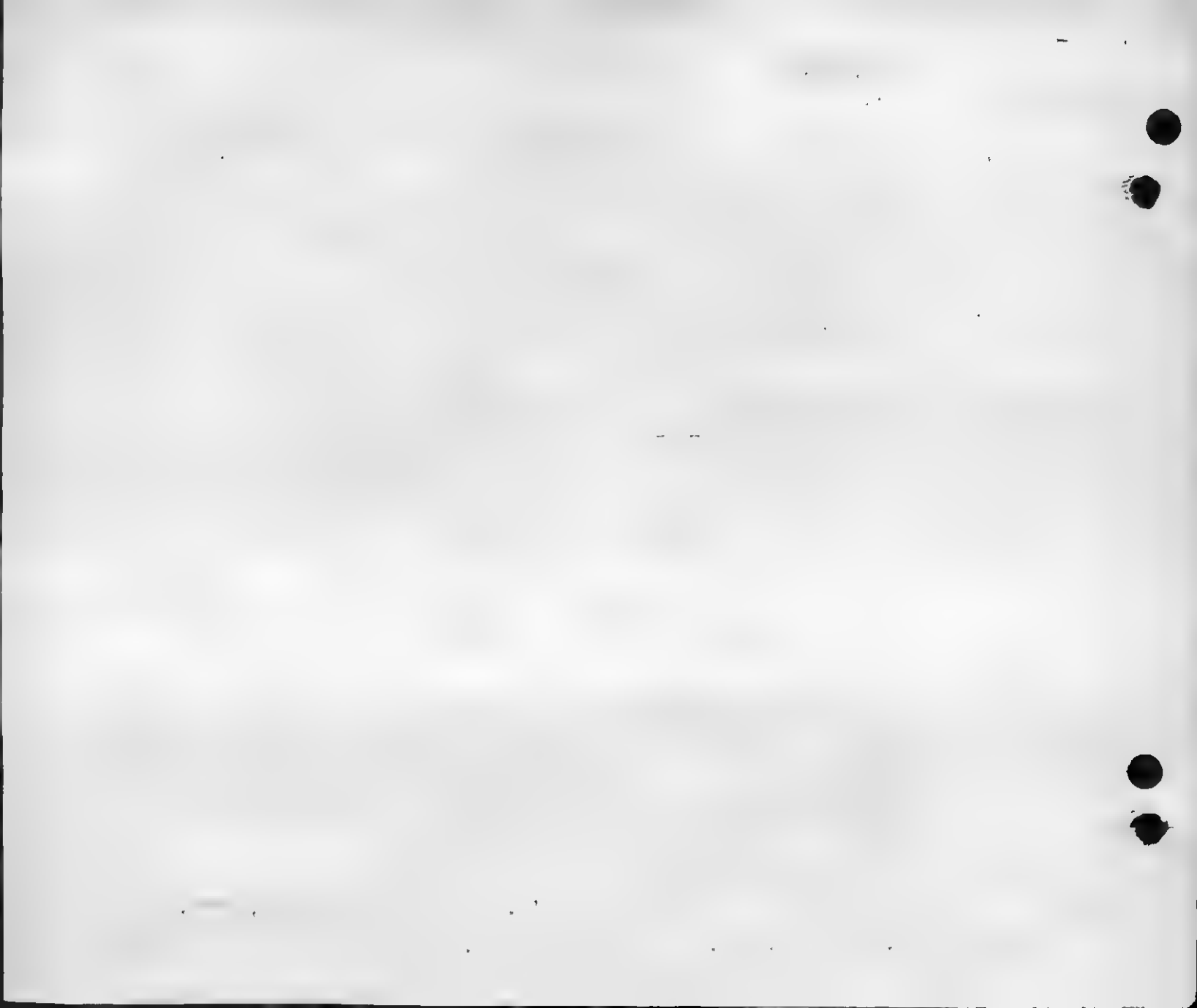
25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 8 FilmG281 2-27-61 et

CERTIFICATE OF DEATH

Reg. Dist. No. 02123

2146

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Boyd's</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Buck Lodge Nursing Home</u>				STREET ADDRESS (If rural give location) <u>2010 Bruce Street</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>EMMA ELIZABETH POWELL</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 21, 1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1870 July 19, 1870</u>	9. AGE last birthday <u>90</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fredrick W. Behrens</u>				14. MOTHER'S MAIDEN NAME <u>Rosa E. ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Fredrick B Powell, Alexandria Va</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Bronchial Pneumonia</u>				2 days			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>				2 years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9 Jan., 1959</u> , to <u>21 Feb., 1961</u> , that I last saw the deceased alive on <u>21 Feb., 1961</u> , and that death occurred at <u>7th</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Edwin M. Smith</u>		M.D.		ADDRESS (Street, city, town, state) <u>Barnesville</u>		DATE SIGNED <u>21 Feb 61</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 24, 1961</u>		NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>C. L. S. P. Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		ADDRESS <u>254 Carroll St NW</u>	
DATE <u>FEB 23 '61</u>							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 6202 3-2-61 et

2147

CERTIFICATE OF DEATH

02124

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL ROCKVILLE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WAVERLEY SANITARIUM</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>PA.</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GETTYSBURG</u> d. STREET ADDRESS <u>7-X</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>ELIA</u> First <u>H</u> Middle <u>PRESTON</u> Last				4. DATE OF DEATH Month <u>2</u> Day <u>13</u> Year <u>1961</u>					
5. SEX <u>FE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>Sept 27-1963</u>		9. AGE (In years last birthday) <u>97</u> 10. IF UNDER 1 YEAR Months Days Hours Min 11. IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Norristown, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>A.G. Rile</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Alexander</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>None</u>		INFORMANT <u>Hospital record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>								INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the deceased from <u>Jan 1, 1959</u> to <u>Feb 18, 1961</u> , that I last saw the deceased alive on <u>Feb 17, 1961</u> , and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above									
ACTUAL SIGNATURE <u>Horace H. Custis Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>1852 Columbia Rd NW, Wash DC</u>				DATE SIGNED <u>2/18/61</u>	
PHYSICIAN'S NAME (Type) <u>HORACE H. CUSTIS JR</u>									
22a. BURIAL, CREMATION, REMOVA. (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>2-20-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 23 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frame</u>	

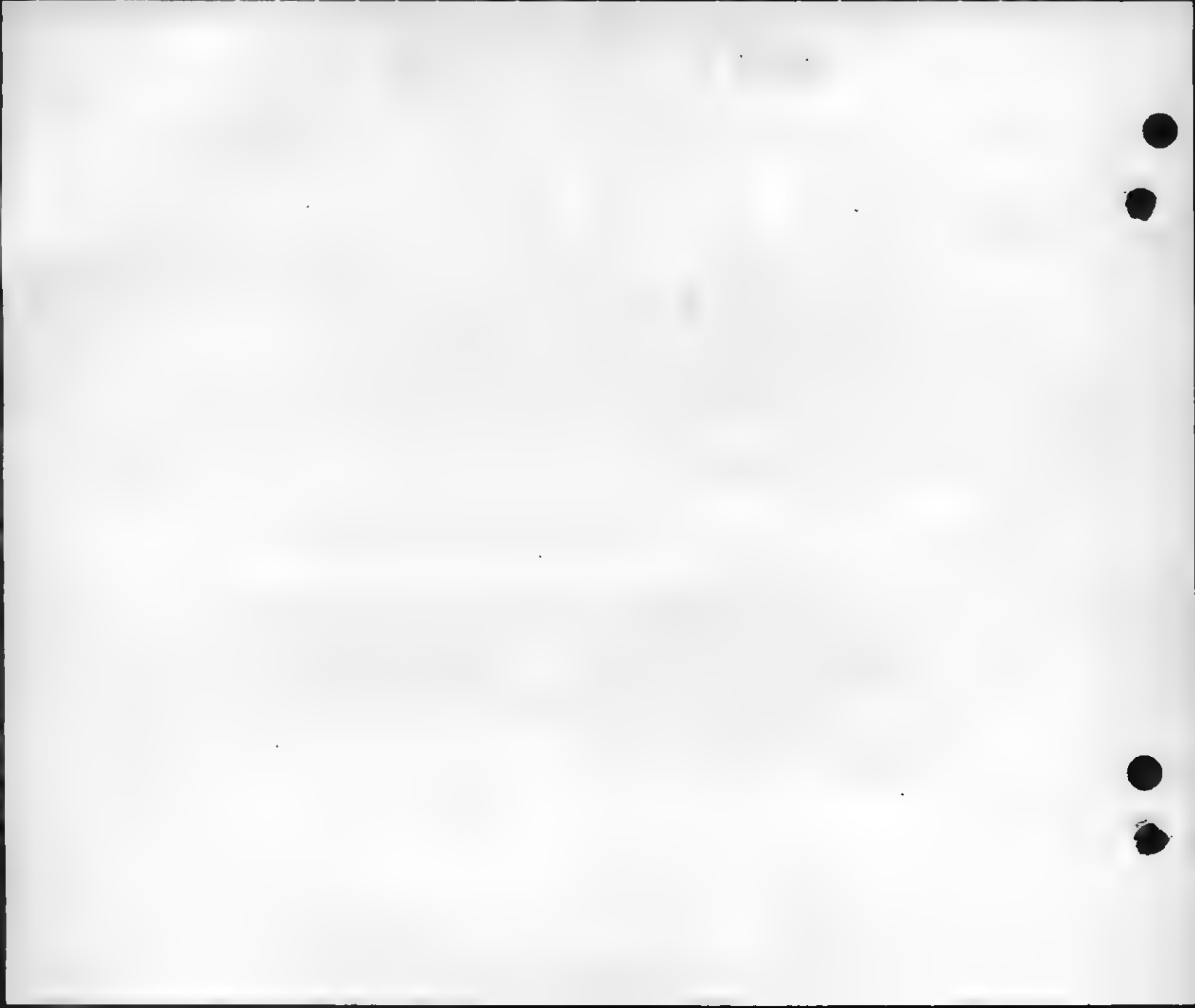
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
 MARYLAND STATE BOARD OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 2148
 CERTIFICATE OF DEATH

02125

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DIST. OF COL. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CONGRESSIONAL MANOR SANITARIUM				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF (Type or print) Adelle S. Price First Middle Last				4. DATE OF DEATH Feb 20 1961 Month Day Year			
5. SEX 7		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-14-1875	
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY - - - -			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME IRVING SPENCE				14. MOTHER'S MAIDEN NAME - - PURNELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - -				16. SOCIAL SECURITY NO. - -			
17. INFORMANT THOMAS M. PRICE Address WASH. D.C. 2202 KALORAMARON							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure DUE TO Chronic pyelonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - - - - DUE TO - - - - (c) - - - -						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year 5:30 p.m. Feb 20 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/31 1961 to 2/20 1961 , that (I) (we) last saw the deceased alive on 2-16 1961 , and that death occurred at 5:30 p.m. from the causes and on the date stated above							
22a. SIGNATURE William L. Howell M.D.				22b. DATE SIGNED Feb 20 1961		22c. PHYSICIAN'S NAME (Type) William L. Howell	
22d. ADDRESS 5401 Western Ave N.W.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL CREMATION REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 2-23-1961		23c. NAME OF CEMETERY OR CREMATORY DARLINGTON CEMETERY		23d. LOCATION (City, town, or county) (State) DARLINGTON, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph J. ... ADDRESS 1756 - ...				25a. REC'D BY REGISTRAR FEB 23 '61		25b. REGISTRAR'S SIGNATURE Arthur L. ...	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other action is necessary, please execute the certificate, writing the word "pending" in pencil in item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case, within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2149 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02120

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY in 1b <u>5 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2025 Forest Hill Dr.</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>12025 Forest Hill Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>Daniel Francis Quigley</u>		4. DATE OF DEATH <u>Feb 2 1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> D. VORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-6-1905</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager Hardware Store</u>		11. BIRTHPLACE (State or foreign country) <u>Mass.</u>	
13. FATHER'S NAME <u>Daniel Quigley</u>		14. MOTHER'S MAIDEN NAME <u>Alma Calnan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>578-05-4207</u>	
17. INFORMANT <u>Francis Quigley (wife)</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u> sudden</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>2</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D.	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>2-6-61</u>		22b. DATE THEREOF <u>2-6-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Andrew Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Princeton, Maryland</u>	
23. FUNERAL DIRECTOR <u>James J. ...</u>		ADDRESS <u>...</u>	
24a. REC'D BY REGISTRAR <u>FEB 6 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. ...</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

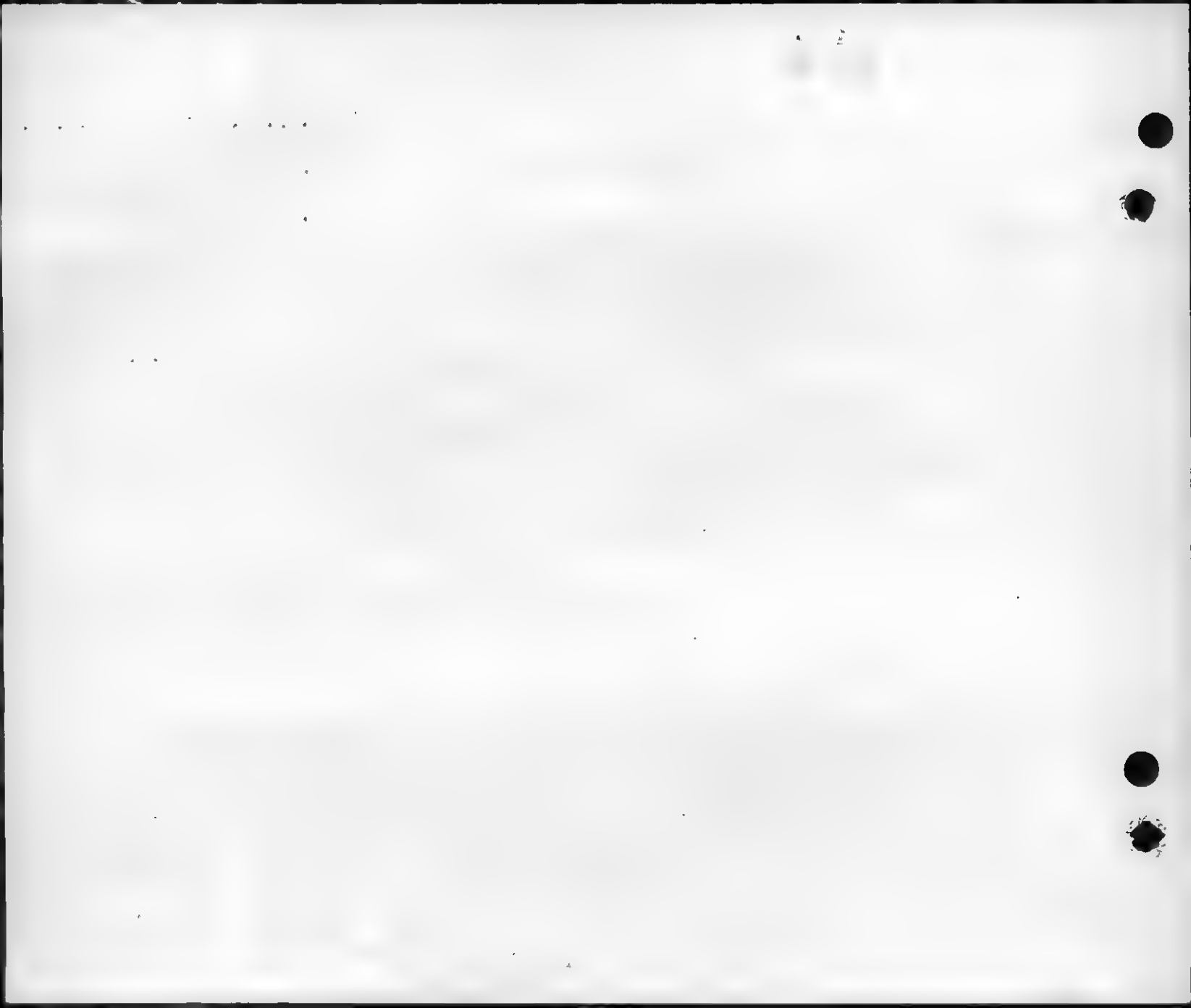
2150

02121

1. PLACE OF DEATH a. COUNTY MONTGOMERY COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE 3801 13th St. N. W. Washington, D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON, MARYLAND				c. LENGTH OF STAY IN 1b 1/26/61 to 2/20/61			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WHEATON NURSING HOME				d. STREET ADDRESS 11901 Georgia Ave.			
3. NAME OF DECEASED (Type or print) CHRISTOPHER First Middle Last RAMMLING				4. DATE OF DEATH Month 2 Day 20 Year 19 61			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/18/1867		9. AGE (In years last birthday) 93 yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME MICHAEL RAMMLING				14. MOTHER'S MAIDEN NAME HORNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ?		17. INFORMANT Nursing Home Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure 422.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 mo. 2 10-520						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/5 19 45 , to 2/20 19 61 , that (I) (we) last saw the deceased alive on 2/20 19 61 , and that death occurred at 4 M, from the causes and on the date stated above.							
22a. SIGNATURE John E. Everett		M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED 2/20/60			
22c. PHYSICIAN'S NAME (Type) JOHN E. EVERETT		22d. ADDRESS 4400 Conn Ave Kensington, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 2/23/61		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE W. H. Jones Co.		ADDRESS 2901-14th St. N.W.		25a. REC'D BY REGISTRAR DATE FEB 23 '61		25b. REGISTRAR'S SIGNATURE C. J. ...	

I

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

102128

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY MONTG.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS SAN.		d. STREET ADDRESS 1810 HYDE CT.	
3. NAME OF DECEASED (Type or print) First MAX Middle RAPHAELSON Last RAPHAELSON		4. DATE OF DEATH Month 2 - Day 17 - Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR-23-1880
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LITHOGRAPHER		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT.	
11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RAPHAEL KIMCHE		14. MOTHER'S MAIDEN NAME JUDITH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT LEONA FRIEDMAN		Address 810 HYDE CT. SPRING, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Transition 1977.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic melanoma of rt. leg DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-25 , 19 57 to 2-17 , 19 61 , that I last saw the deceased alive on 2-16 , 19 61 , and that death occurred at 4:35 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Jason Geiger		ADDRESS (Street, city or town, state) 1110 SPRING ST. SILVER SPRING, MD.	
PHYSICIAN'S NAME (Type) JASON GEIGER		DATE SIGNED 2-17-61	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/19/61	22c. NAME OF CEMETERY OR CREMATORY GEO. WASH. CEM.	22d. LOCATION (City, town, or county) (State) HYATTSVILLE, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home		24a. REC'D BY REGISTRAR 4217-9th St.	24b. REGISTRAR'S SIGNATURE CLARA E. KRAMA

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2152

02109

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SANITARIUM</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MD</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>1604 LADD ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>WILLIAM A. RAUCH</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>24</u> Year <u>1961</u>		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-27-06</u>		9. AGE (In years last birthday) <u>54 yrs</u>		10. IF UNDER 1 YEAR Months _____ Days _____		11. IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Draftsman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U S GOV</u>				11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON DC</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>HARRY C RAUCH</u>				14. MOTHER'S MAIDEN NAME <u>MINNA BUCKEL</u>				15. WAS DECEASED EVER IN U S. ARMED FORCES? (Yes, no, or unknown) _____				16. SOCIAL SECURITY NO. _____				17. INFORMANT <u>MARY M. RAUCH</u> Address <u>1604 Ladd St</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>meningo-encephalitis</u> (b) <u>Pneumococcus infection</u> (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of item 18.)				20c. TIME OF INJURY Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 23, 1961</u> to <u>Feb 24, 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb 24, 1961</u> , and that death occurred at _____ M, from the causes and on the date stated above.																			
22a. SIGNATURE <u>Edward J. Richards</u> M.D.				22b. DATE SIGNED <u>2-26-61</u>				22c. PHYSICIAN'S NAME (Type) _____				22d. ADDRESS <u>10110 GA. AVE Silver Spring</u>							
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2-27-61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>				23d. LOCATION (City, town or county) <u>Swetland Md</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Neal Funeral Home</u>				24b. ADDRESS <u>4812 Balboa Washington DC</u>				25a. REC'D BY REGISTRAR <u>Charles S. Kraus</u>				25b. REGISTRAR'S SIGNATURE _____							

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 12130

2153

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home			d. STREET ADDRESS 697 Glalstone Ave.		
3. NAME OF DECEASED (Type or print) First Beulah Middle Ulrica Last Richards			4. DATE OF DEATH Month Feb. Day 10 Year 1961		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1871		9. AGE (In years last birthday) 89 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Theodore Augusta Richards			14. MOTHER'S MAIDEN NAME Emma Frances Broughton		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		INFORMANT Address Gaithersburg Asbury Methodist Home Records. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive-Arteriosclerotic Cardiovascular Disease					INTERVAL BETWEEN ONSET AND DEATH 1 week
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from Oct 15, 1960 to Feb 10, 1961 , that I last saw the deceased alive on Feb 7, 1961 , and that death occurred at 6:30 AM , from the causes and on the date stated above.					
ACTUAL SIGNATURE James W. Egan		M.D. 7720 Wisconsin Ave.		DATE SIGNED 2-10-61	
PHYSICIAN'S NAME (Type) James W. Egan		Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-13-61		22c. NAME OF CEMETERY OR CREMATORY Forest Oak	
22d. LOCATION (City, town, or county) Gaithersburg, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner.		ADDRESS Gaithersburg, Md.		24a. RECD. BY REGISTRAR FEB 14 1961	
24b. REGISTRAR'S SIGNATURE Arthur J. Thomas		DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 12154

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington Md</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chary Chase Md 51</i>	
c. LENGTH OF STAY IN 1b <i>3 months</i>		d. STREET ADDRESS <i>3617 Glenmore Dr.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Correll Hall Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>L AND</i> First Middle Last <i>Ritter</i>		4. DATE <input checked="" type="checkbox"/> DEATH <i>Feb. 5 1961</i> Month Day Year	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-24-79</i>
9. AGE (In years last birthday) <i>82</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	
11. BIRTHPLACE (State or foreign country) <i>D.C.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Carl Heppner</i>		14. MOTHER'S MARDEN NAME <i>Margaret Dietz</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <i>Chas. H. Ritter</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary insufficiency</i> DUE TO (b) <i>Arteriosclerotic Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fractured left hip</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Fall from bed.</i>	
20c. TIME OF INJURY Month Day Year <i>6:30 p.m. Oct. 24 1960</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) (County) (State) <i>Chary Chase Mont. Md.</i>
21. I certify that I attended the deceased from <i>10/28, 1961</i> to <i>present</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>1/30, 1961</i> , and that death occurred at <i>6 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John B. Umhan</i> M.D.		ADDRESS (Street, city or town, state) <i>8805 Conn. Ave. Chevy Chase 15 Md</i>	
DATE SIGNED <i>2/5/61</i>			
PHYSICIAN'S NAME (Type) <i>John B. Umhan</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>2-8-61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Southwest Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>L. H. Farmer</i>		ADDRESS <i>Home - P.E.</i>	
24a. REC'D BY REGISTRAR DATE <i>FEB 8 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kew</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be returned to the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2155

CERTIFICATE OF DEATH

Reg. Dist. No. 02132

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 18 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9117 GLENRIDGE ROAD		e. STREET ADDRESS 9117 GLENRIDGE ROAD	
3 NAME OF DECEASED (Type or print) First Middle Last KENNETH NORMAN RYAN		4. DATE OF DEATH Month Day Year FEB. 1 1961	
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12/27/02
9. AGE (In years last birthday) 58		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accounts officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't. Library of Congress	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME JAMES RYAN		14. MOTHER'S MAIDEN NAME EDNA SALTER	
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT Mrs. Mary C. Ryan, 9117 Glenridge Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Artery Occlusion & Extension Silver Spring Md DUE TO (b) Chronic Arterio Sclerosis particularly Coronary Arteries DUE TO (c) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. INTERVAL BETWEEN ONSET AND DEATH 10 hours - 4 Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1950 to 2-1-1961, that I last saw the deceased alive on 2-1-1961, and that death occurred at 8:29 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE N. C. Shoemaker		ADDRESS (Street, city or town, state) DATE SIGNED 8005 Woodbury Dr. - Silver Spring, Md - 2-1-61	
PHYSICIAN'S NAME (Type) N. C. Shoemaker			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/4/61	22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY	22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS WANNER E. PUMPHREY INC SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE FEB 9 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

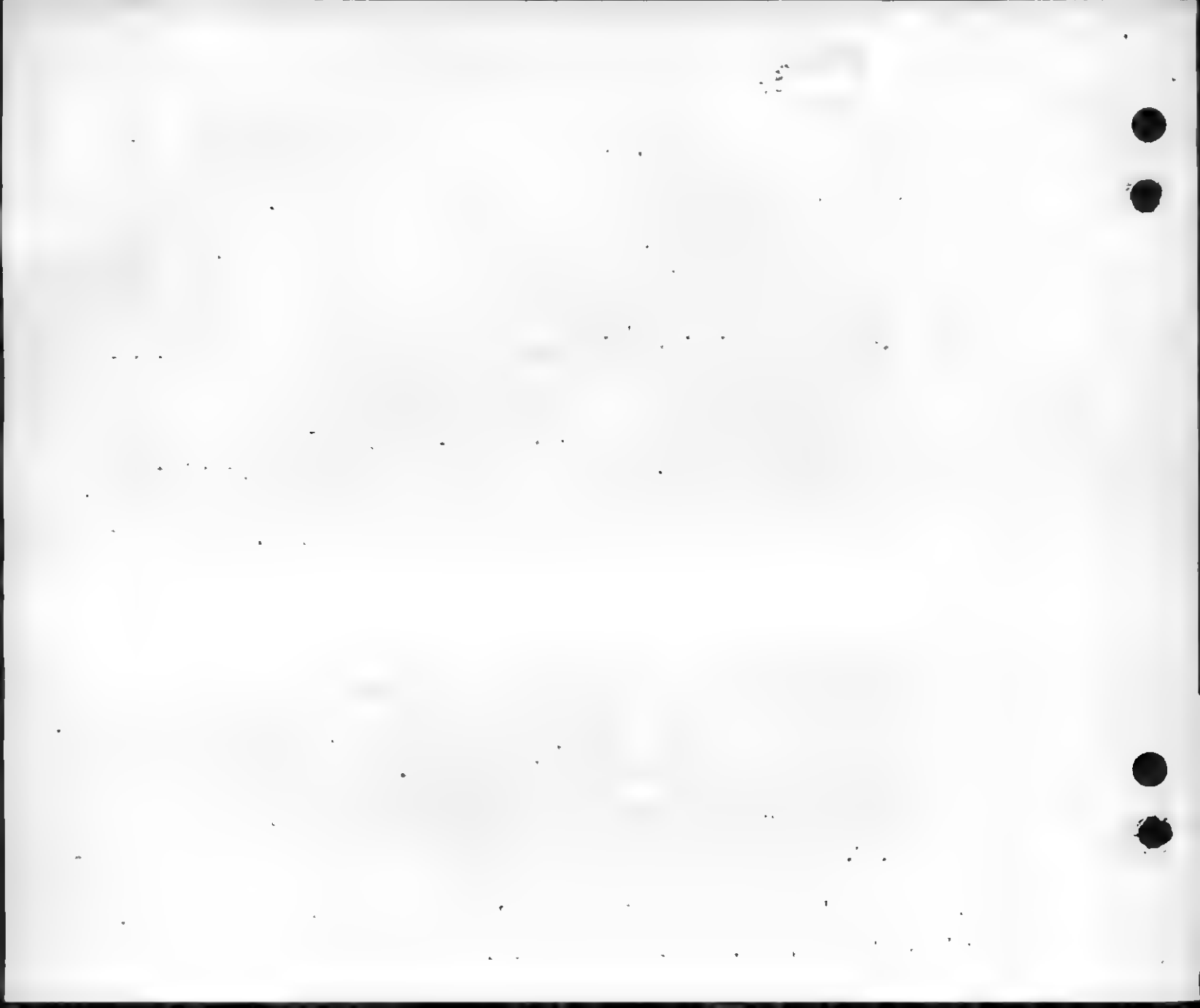
1 412

Page 4

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



Page 4
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

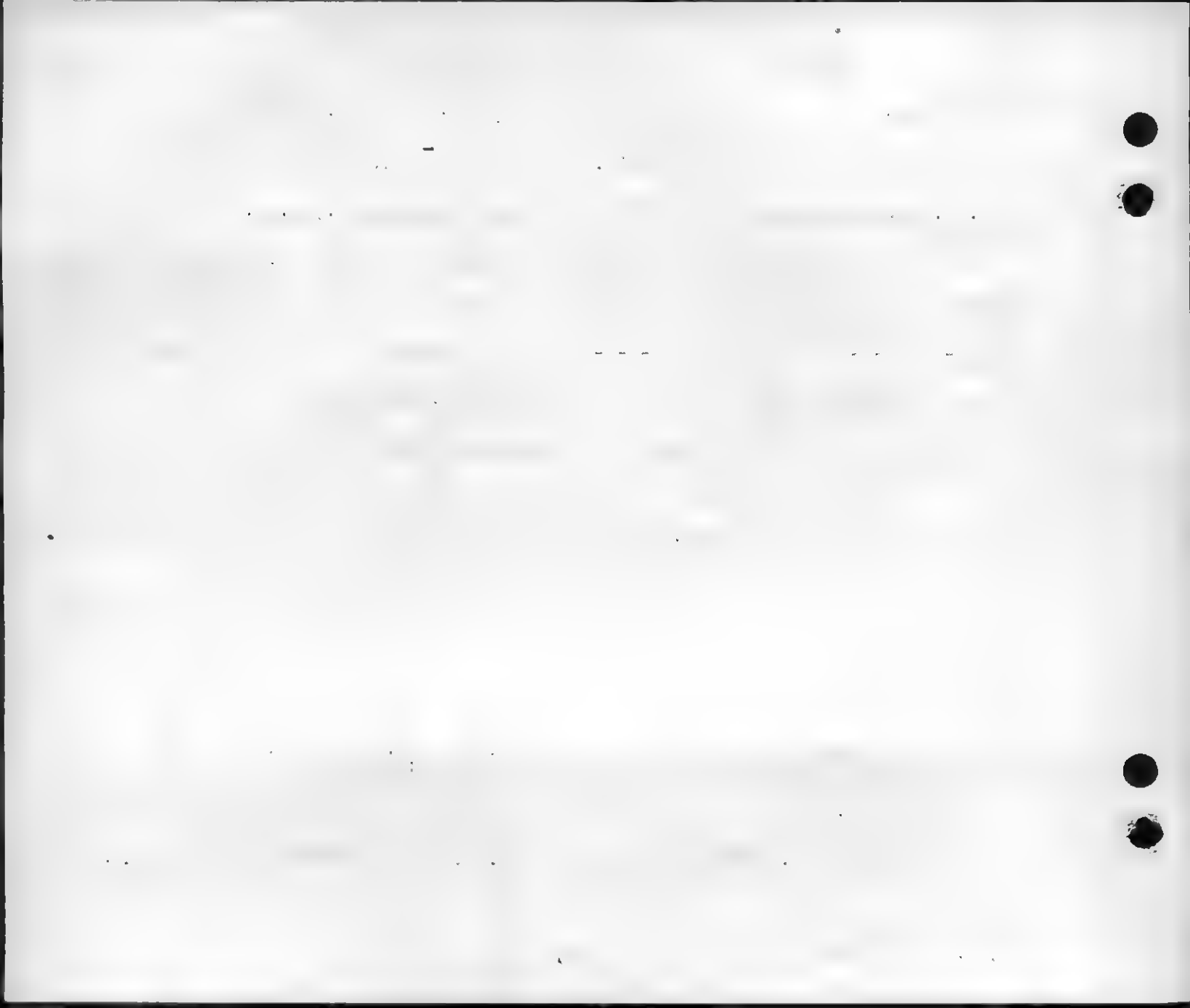
2156

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02143

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural) c. LENGTH OF STAY IN 1b 26 min.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, d. STREET ADDRESS 364 Chaplin St., S. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SEENEY		4. DATE OF DEATH Month Day Year February 5 1961	
5. SEX Female 6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 2-5-61 9. AGE (in years, last birthday) 26 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Emmett Roland SEENEY		14. MOTHER'S MAIDEN NAME Joan M. WILLIAMS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None 17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7x2.8 Anoxia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) neonatal atelectasis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 26 min. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 5 1961 to Feb. 5 1961, that (I) (we) last saw the deceased alive on Feb. 5 1961, and that death occurred at 1:05 PM, from the causes and on the date stated above			
22a. SIGNATURE Robert V. Rack M.D. 22b. DATE SIGNED 2-6-61		22c. PHYSICIAN'S NAME (Type) Robert V. RACK, LT, MC, USN 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-14-61 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Arlington, Virginia 23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE W.E. Jarvis Funeral Home, 1432 U St., NW, WashDC		25a. REC'D BY REGISTRAR DATE FEB 10 '61 25b. REGISTRAR'S SIGNATURE	

51192XV6



Page 4
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

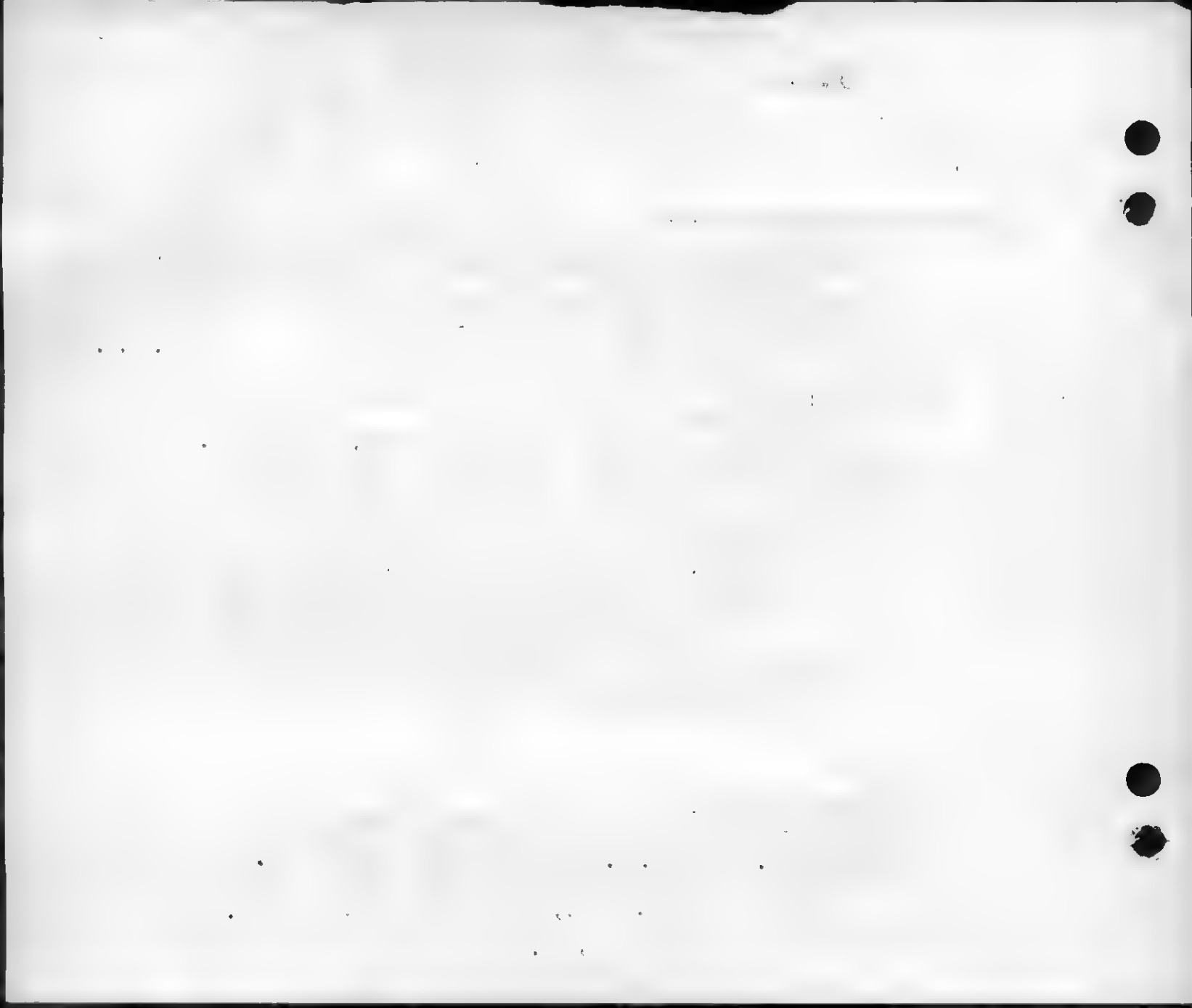
VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2157

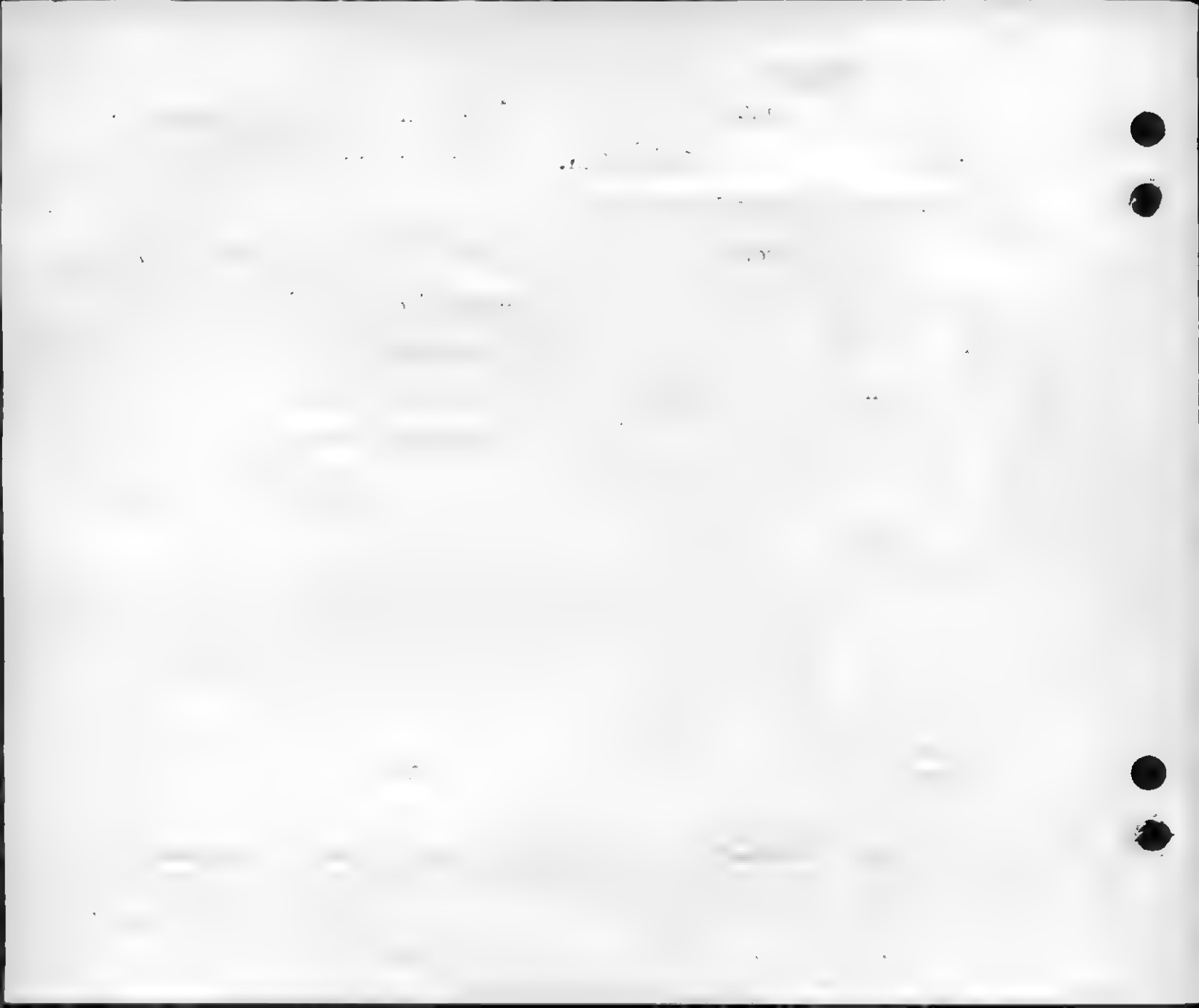
02164

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		MARYLAND c. LENGTH OF STAY IN 1b 19 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) OLNEY		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3 NAME OF DECEASED (Type or print) IRENE SHERMAN SELBY		First Middle Last		4. DATE OF DEATH Month Day Year FEBRUARY 10 19 61		5. SEX FEMALE		6 COLOR OR RACE NEGRO		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8 DATE OF BIRTH 5/21/08		9 AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME MESSIAH ADDISON		14. MOTHER'S MAIDEN NAME ANNIE VIRGINIA WILLIAMS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17 INFORMANT HOSPITAL RECORDS, OLNEY, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) UREMIA 592X DUE TO CHRONIC GLOMERULONEPHRITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. HYPERTENSIVE HEART DISEASE (b) HYPERTENSIVE HEART DISEASE (c) HYPERTENSIVE HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH 2 WK Yxs Yxs		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.		22a. SIGNATURE Charles H. Ligon M D		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b. DATE SIGNED 2/10/61		22c. PHYSICIAN'S NAME (Type) CHARLES H. LIGON, M. D.		22d. ADDRESS SANDY SPRING, MD.		23a. BURIAL, CREMATION REMOVED (Specify) Burial		23b. DATE THEREOF 2/13/61		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion.,		23d. LOCATION (City, town, or county) (State) Mt. Zion, Md.			
24 FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR DATE FEB 15 '61		25b. REGISTRAR'S SIGNATURE C. J. S. Harris													



02135

VR A15 (4)
15M 9/59



1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film G281 2/23/61 mh

2159 CERTIFICATE OF DEATH

Reg. Dist. No.

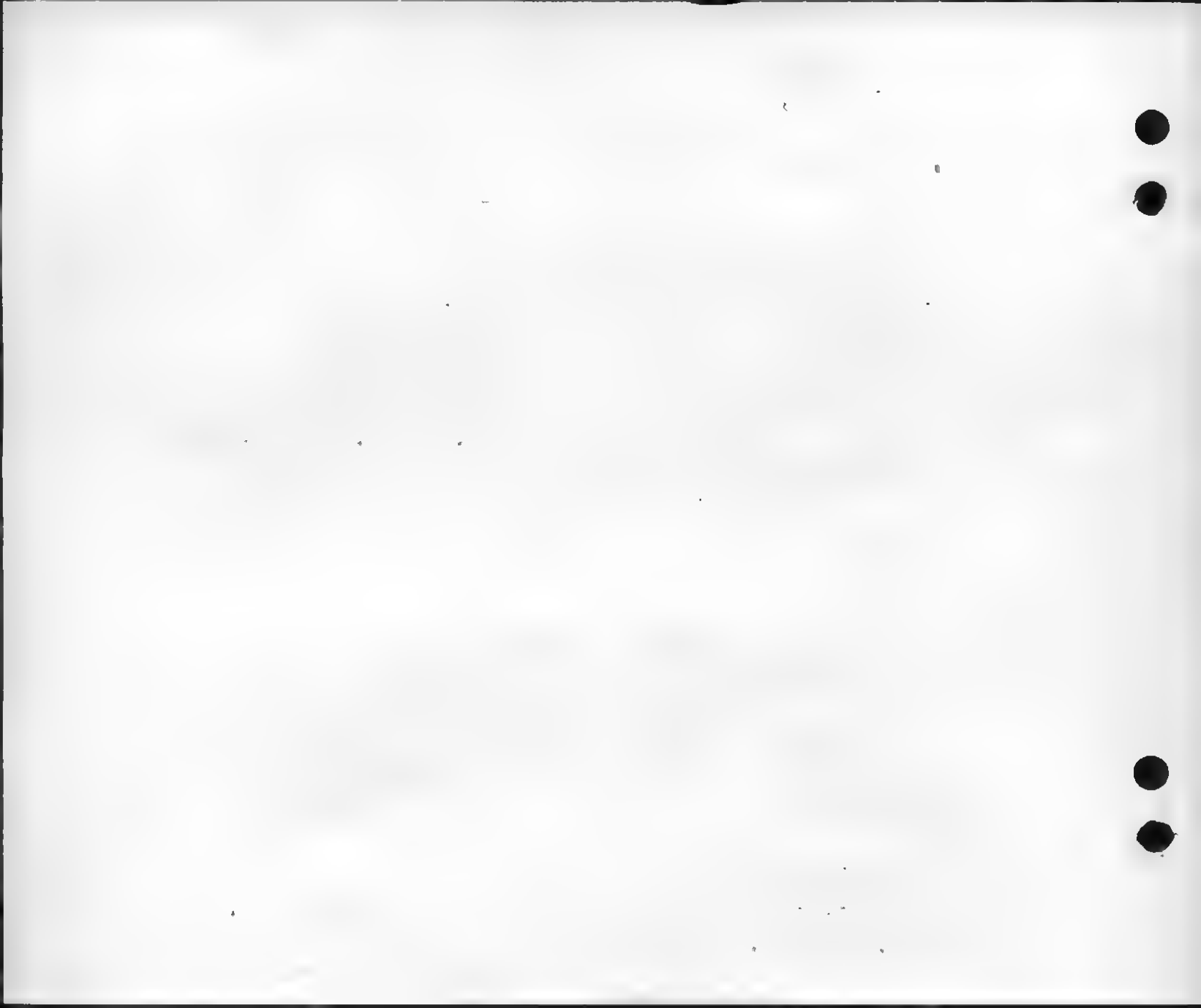
02136

1 PLACE OF DEATH a. COUNTY Montg, MARYLAND		2. USUAL RESIDENCE (Where deceased lived If first listed on Residence before admission) a. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 2-Cedar Ave	
3 NAME OF DECEASED (Type or print) First Effie Middle Pearl Last Shankle		4. DATE OF DEATH Month Feb Day 15 Year 1961	
5 SEX Female	6 CO. OR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Dec 15-1903
9. AGE (in years last birthday) 57 yrs		10. IF UNDER 1 YEAR Months 2 Days Hours Min 	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Home Work	11. BIRTHPLACE (State or foreign country) Canada
12. CITIZEN OF WHAT COUNTRY? United States			
13 FATHER'S NAME Smith		14. MOTHER'S MAIDEN NAME Irene Etter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16 SOCIAL SECURITY NO	
INFORMANT Roy M. Smith		Address 2-Cedar Ave Gaithersburg, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov , 19 60 , to Feb. 15 , 19 61 , that I last saw the deceased alive on Feb. 15 , 19 61 , and that death occurred at 10:50 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Jack Schumacher M.D.		ADDRESS (Street, city or town, state) 105 Russell Ave. Gaithersburg, Md.	
PHYSICIAN'S NAME (Type) Jack Schumacher		DATE SIGNED 2-16-61	
22a. BURIAL, CREMATION REMAINS (Type)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
burial	2-17-61	ParkLawn	Rockville. Md.
23 FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg. Md.		24a. REC'D BY REGISTRAR FEB 20 '61	24b. REGISTRAR'S SIGNATURE Arthur L. Howard

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed on 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

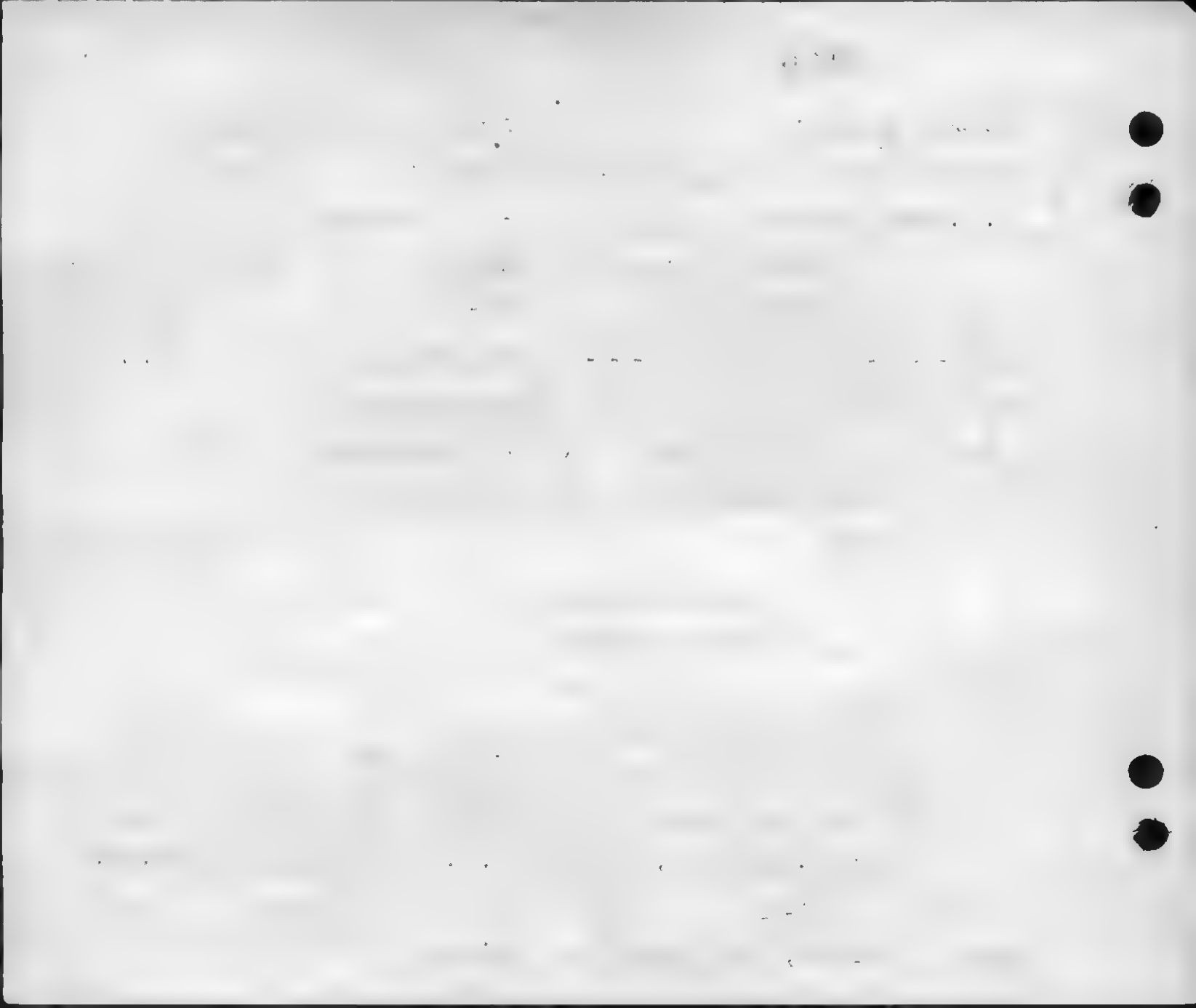
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2160

02153

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>17 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> d. STREET ADDRESS <u>1415 S. Edgewood - Apt. 464</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Kevin Creighton SIMPSON</u>		4. DATE OF DEATH <u>February 21 1961</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>Caucasian</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>2-21-61</u>		9. AGE (in years last birthday) <u>17</u> IF UNDER 1 YEAR Months <u>17</u> Days <u>42</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Ottis J. SIMPSON</u> 14. MOTHER'S MAIDEN NAME <u>Mary E. PARKER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>(F) O.J. Simpson, same as #2 above</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>APNEA NEONATORUM</u> (b) <u>762-5</u> DUE TO <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u> (c) <u>DUE TO</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>POST MATURITY</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Feb. 21 1961</u> to <u>Feb. 21 1961</u> that <u>1</u> (we) last saw the deceased alive on <u>Feb. 21 1961</u> , and that death occurred at <u>7:45 PM</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Fred W. Grello</u>		22b. DATE SIGNED <u>2-22-61</u>		22c. PHYSICIAN'S NAME (Type) <u>Fred W. GRELLO, LT, MC USN</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-24-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>			
23d. LOCATION (City, town or county) <u>Arlington</u>		(State) <u>Virginia</u>		25a. REC'D BY REGISTRAR <u>Arthur L. Kraus</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Murphy Funeral Home, 3524 Columbia Pike, Arlington</u>		25b. REGISTRAR'S SIGNATURE <u>Feb 27 '61</u>		25c. REGISTRAR'S SIGNATURE <u>Feb 27 '61</u>			

2051324



Page 4
TO HOSPITAL: The attending physician: The local health officer: The death certificate be executed within 24 hours after the death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

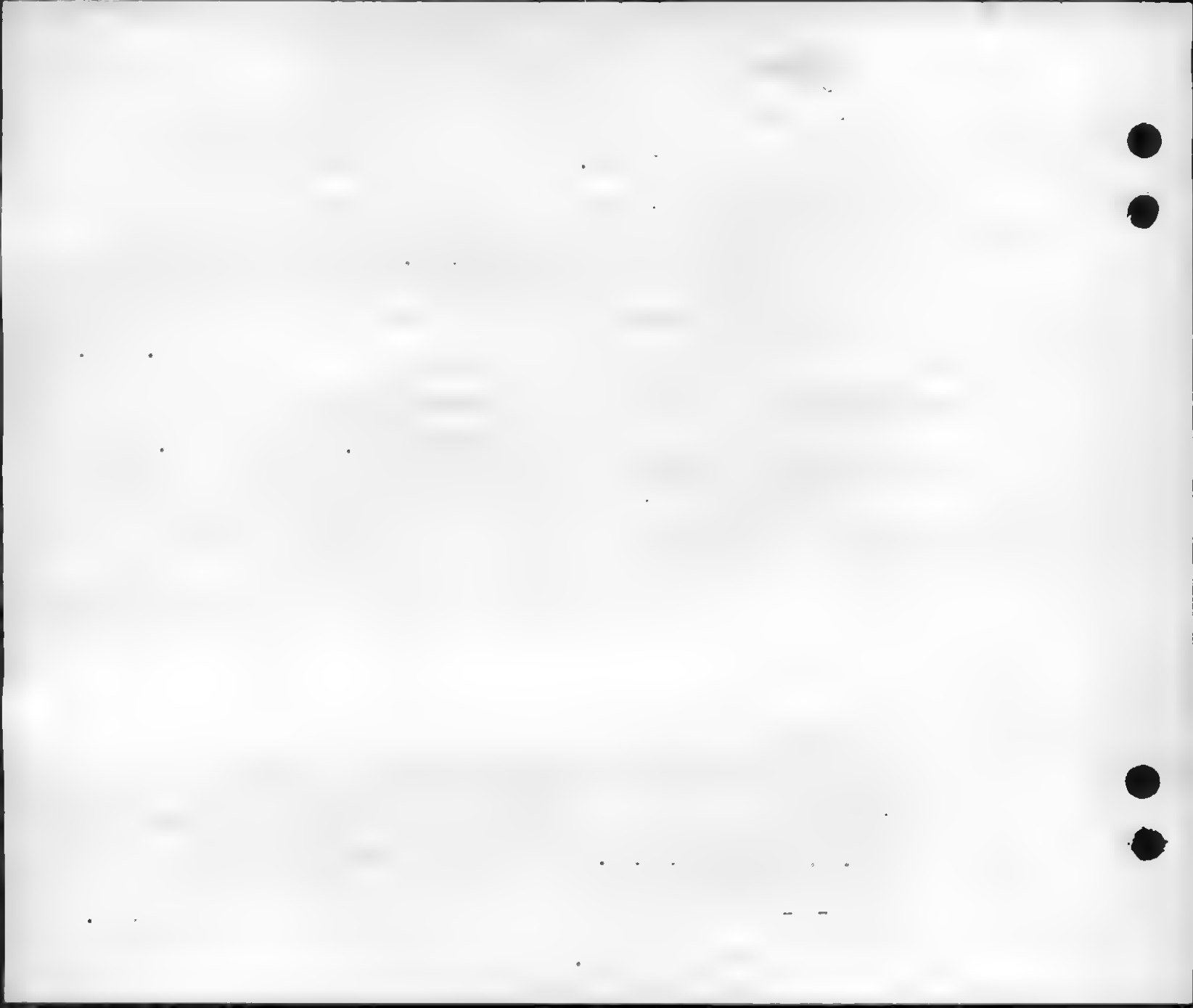
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2161

CERTIFICATE OF DEATH

02158

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 31 HRS. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG d. STREET ADDRESS 211 LEE STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LLOYD RONALD SMITH, JR.		4. DATE OF DEATH Month Day Year FEBRUARY 24 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/22/61
9. AGE (In years last birthday) yrs 12		10. IF UNDER 1 YEAR Months Days Hours Min. 12 13	11. IF UNDER 24 HRS Hours Min. 13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN, OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME LLOYD RONALD SMITH		14. MOTHER'S MAIDEN NAME MARGARET MAE BART	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT HOSPITAL RECORDS,		Address OLNEY, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis 12.5 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Immaturity + Prematurity DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 22, 1961 , to Feb. 24, 1961 , that (I) (we) last saw the deceased alive on Feb. 23, 1961 , and that death occurred at 4:45 AM , from the causes and on the date stated above.			
22a. SIGNATURE Dr. J. Schumacher		22b. DATE 2-24-61	
22c. PHYSICIAN'S NAME (Type) DR. J. SCHUMACHER, M. D.		22d. ADDRESS GAITHERSBURG, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-25-61	
23c. NAME OF CEMETERY OR CREMATORY Flower Hill		23d. LOCATION (City, town, or county) (State) Redland Montgomery, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		25a. REC'D BY REGISTRAR DATE FEB 28 '61	
ADDRESS Laytonsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2162

02133

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u> c. LENGTH OF STAY IN Bldg. <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium</u>				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md.</u> d. STREET ADDRESS <u>2015 Woodberry St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Grace</u> First <u>Mae</u> Middle <u>Spangenberg</u> Last				4. DATE OF DEATH Month <u>Feb</u> Day <u>20</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/7/89</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Kimble</u>				14. MOTHER'S M maiden name <u>DeLong</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Harold Spangenberg (Same as #2)</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Coronary Arteriosclerosis with</u> <u>Massive Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>2/10/61</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>6/24/43</u> to <u>2/20/61</u> , that (I) (we) last saw the deceased alive on <u>2/20/61</u> , and that death occurred at <u>10:15</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Howard T. Morse</u>				22b. DATE SIGNED <u>2/20/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Howard T. Morse</u>				22d. ADDRESS <u>7030 Carroll Ave Takoma Park Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/23/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lakeview Cemetery</u>		23d. LOCATION (City, town or county) <u>Lakeview, Pa.</u> (State) <u> </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				25. REC'D BY REGISTRAR <u> </u> DATE <u>FEB 23 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 1/60



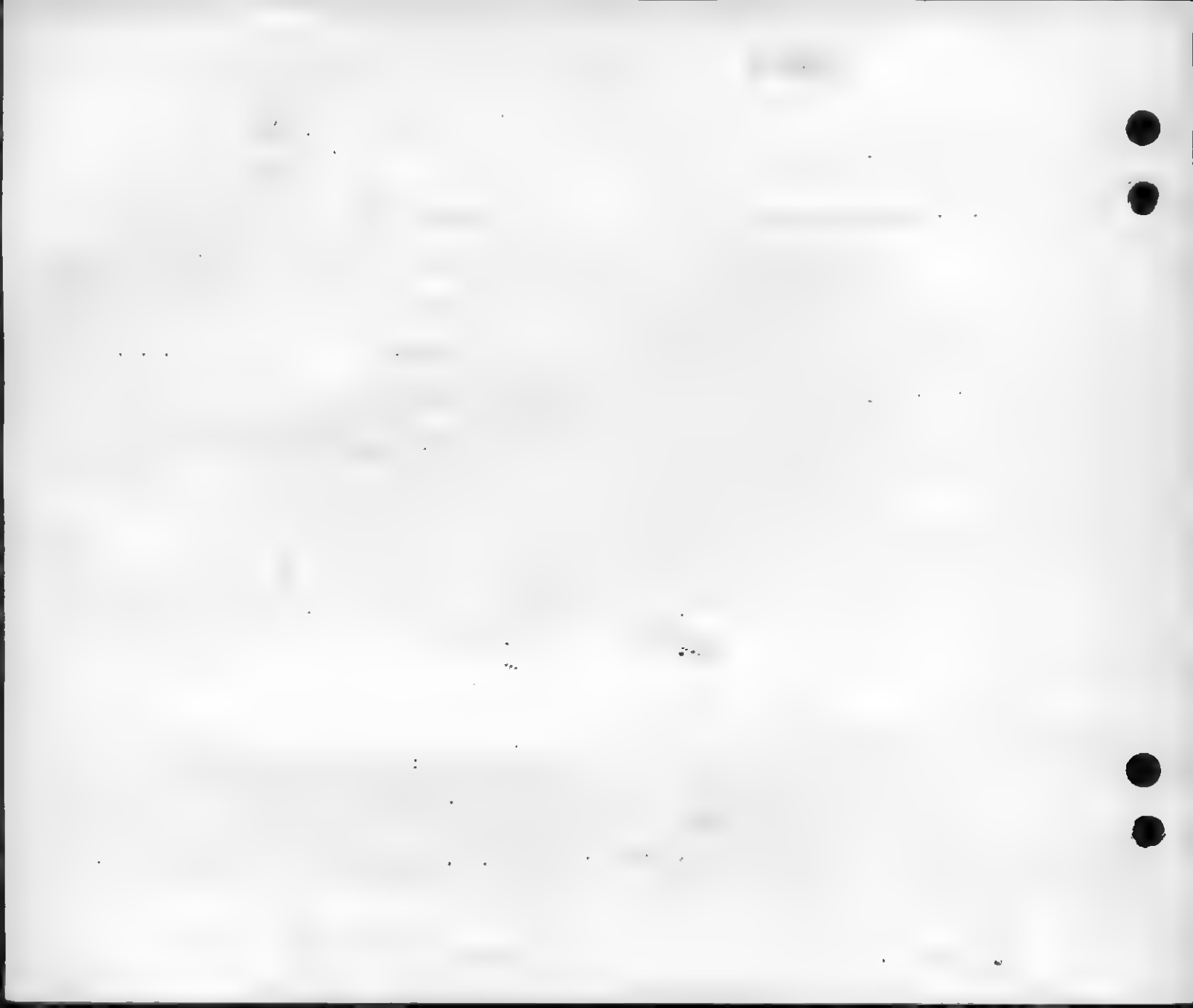
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2163

02140

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE Rhode Island b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 15 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 86 Rhode Island Ave.			
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Ramsay STAPLER				4. DATE OF DEATH Month Day Year February 4 1961			
5 SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-17-82		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - -		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13 FATHER'S NAME Henry RAMSAY				14. MOTHER'S MAIDEN NAME Julia COOKE			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16 SOCIAL SECURITY NO.		17 INFORMANT Address (H) John T.G. Stapler, same as #2 above	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Pulmonary Embolism DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan. 20 1961 to Feb. 4 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Feb. 4 1961 , and that death occurred at 2:10AM M, from the causes and on the date stated above 22a SIGNATURE William P. Baker M D ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> 22b DATE SIGNED 2-4-61 22c PHYSICIAN'S NAME (Type) William P. BAKER, LT, MC, USN 22d ADDRESS U. S. Naval Hospital, Bethesda, Md.							
23a BURIAL, CREMATION, REMOVA. (Specify) Burial		23b DATE THEREOF 2-7-61		23c NAME OF CEMETERY OR CREMATORY Arlington National		23d LOCATION (City, town, or county) (State) Arlington Virginia	
24 FUNERAL DIRECTOR'S SIGNATURE Jos. Gawlers' Sons				25a. REC'D BY REGISTRAR FEB 7 '61		25b REGISTRAR'S SIGNATURE - 2 -	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The attending physician and complete y filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the pages are missing, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

216 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02141

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Resmor Sanitarium and Hospital		d. STREET ADDRESS 5721 Grosvenor Lane, Bethesda	
3. NAME OF DECEASED (Type or print) Virginia Belle Staub		4. DATE OF DEATH February 19 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 January 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
13. FATHER'S NAME Richard S. Gaskins		14. MOTHER'S MAIDEN NAME Hinnick	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO., 17. INFORMANT Wm. H. Gaskins Address Edgewater, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) Hypertension & Cardiovascular disease DUE TO (c) Aspiration of left leg in 1958 following a fracture Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Found dead in bed 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aspiration of left leg in 1958 following a fracture		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschert		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BROSCHE		ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED Feb 19-61	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/21/61	22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	22d. LOCATION (City, town, or country) (State) Washington, D. C.
23. FUNERAL DIRECTOR Joseph F. Birch's Sons		24a. REC'D BY REGISTRAR FEB 23 '61	
ADDRESS Yach, D.C.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2165

2165

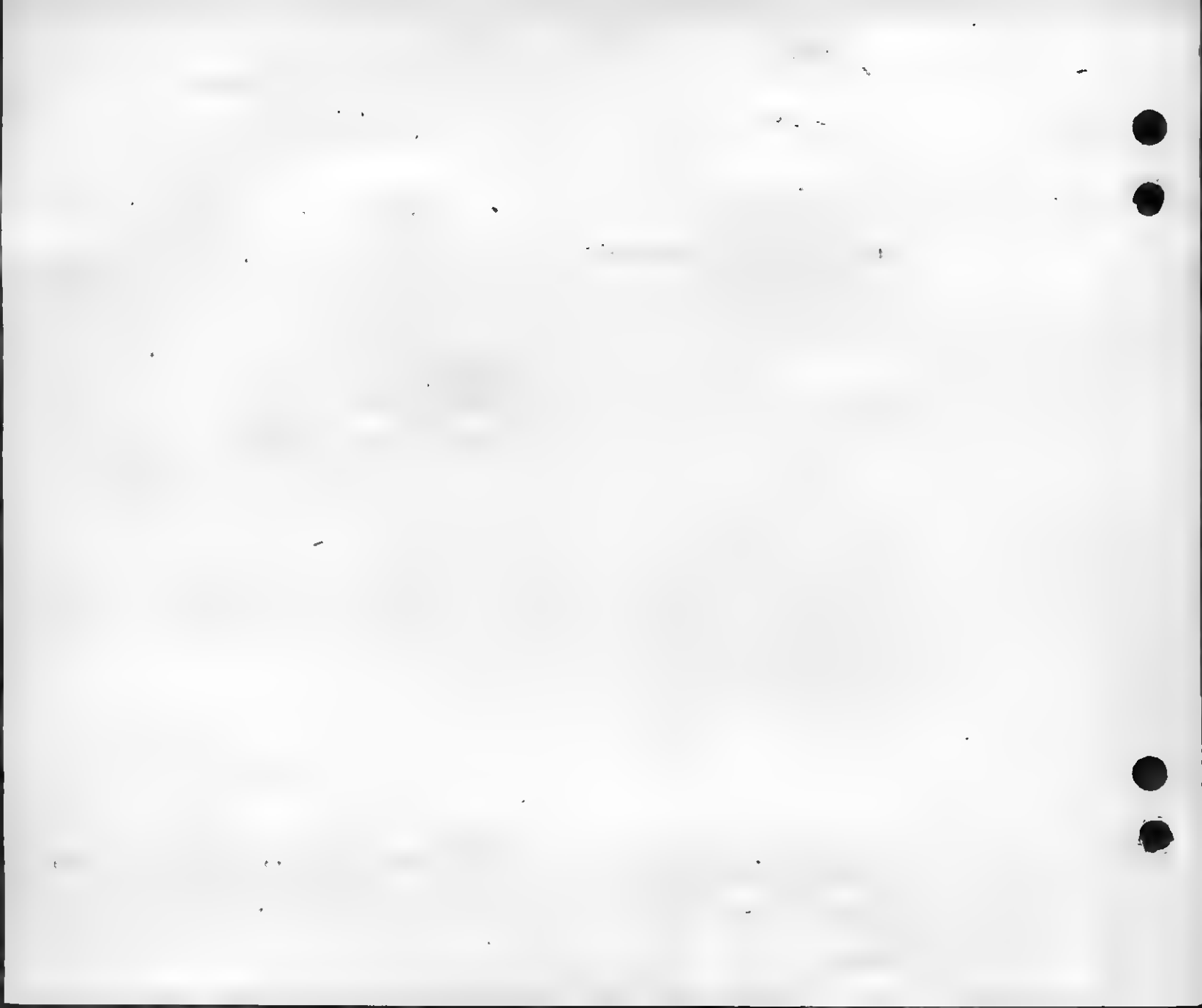
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02142

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton Nursing Home, Wheaton, Md c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington D.C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wheaton Nursing Home		d. STREET ADDRESS 2122 California St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Orithia Josepline Steenis First Middle Last		4. DATE OF DEATH Feb. 18 1961 Month Day Year	
5. SEX female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1872
9. AGE (In years last birthday) 88 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) NEW YORK, New York		12. CITIZEN OF WHAT COUNTRY? Am.	
13. FATHER'S NAME Spencer Halt		14. MOTHER'S MAIDEN NAME ORENTHIA Clark	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO none	
17. INFORMANT Nursing Home records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic heart disease DUE TO (c) 4-5 yrs		INTERVAL BETWEEN ONSET AND DEATH 4-5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old age & debility		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1956 to Feb 18 1961 , that (I) (we) last saw the deceased alive on Jan 15 1961 , and that death occurred at 10 AM, from the causes and on the date stated above			
22a. SIGNATURE Oliver E. Thompson		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Oliver E. Thompson		22d. ADDRESS 901 Pershing Dr., Silver Spring, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 2/20/1961	
23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d. LOCATION (City, town, or county) (State) Rockford, Illinois	
24. FUNERAL DIRECTOR'S SIGNATURE James Lawrence		25a. REC'D BY REGISTRAR DATE FEB 20 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. House			

(M)

(I)



Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

2166

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02143

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Washington, D. C. b. COUNTY Washington, D. C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, 10 d. STREET ADDRESS A713 The Woodner e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last David Darrin STEINBERG		4. DATE OF DEATH Month Day Year February 14 1961	
5 SEX Male	6 COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12-17-56
9 AGE (In years last birthday) 4 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----	11. BIRTHPLACE (State or foreign country) Washington, D. C.
12 CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Harvey STEINBERG		14. MOTHER'S MAIDEN NAME Annette WALLACE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17 INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Neuroblastoma, disseminated 173.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 8 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (u) (this hospital) attended the deceased from Feb. 13 1961 , to Feb. 14 1961 that (u) (we) last saw the deceased alive on Feb. 14 1961 , and that death occurred at 12PM , from the causes and on the date stated above			
22a. SIGNATURE Robert V. Rack		22b DATE SIGNED 2-15-61	
22c PHYSICIAN'S NAME (Type) Robert V. RACK, LT, MC, USN		22d ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-17-61	
23c NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24 FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.		25a. REC'D BY REGISTRAR WashDC	
25b. REGISTRAR'S SIGNATURE Simmons Bros. Funeral Home, 1661 Good Hope Rd. SE		25c. DATE FEB 17 '61	



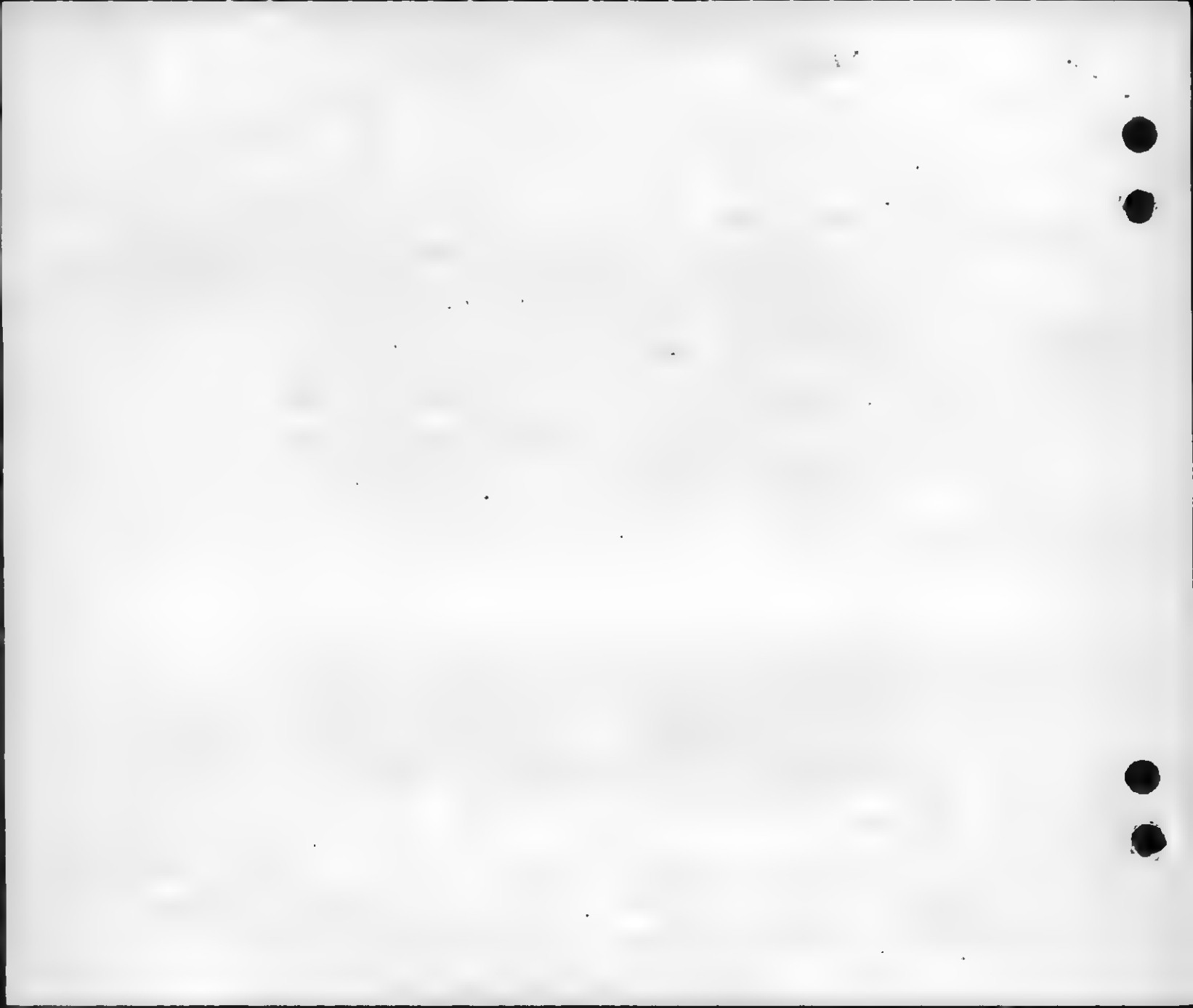
Page 4
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.
TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2167
CERTIFICATE OF DEATH

02144

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 5	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4529 Windsor Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Oscar Middle J Last Stephens		4. DATE OF DEATH Month February Day 19 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1885
9. AGE (in years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months 8 Days 25 Hours Min 	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Oscar J. Stephens		14. MOTHER'S MAIDEN NAME Catherine Lowe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Eudora Stephens-Wife-same 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) ventricular fibrillation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) coronary occlusion DUE TO (c) arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None INTERVAL BETWEEN ONSET AND DEATH 5 min 15 min 5 year			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 1960 to February 1961 , that (I) (we) last saw the deceased alive on Feb 12 1961 , and that death occurred on Feb 12 1961 , from the causes and on the date stated above.			
22a. SIGNATURE Thomas F. O'Connor		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) THOMAS F. O'CONNOR		22d. ADDRESS 4861 BATTEAY LANE BETHESDA 141, MD	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/22/61	
23c. NAME OF CEMETERY OR CREMATORY All Sts. Church Cem.		23d. LOCATION (City, town, or county) (State) Oakley, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR DATE FEB 21 '61	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Knead	



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

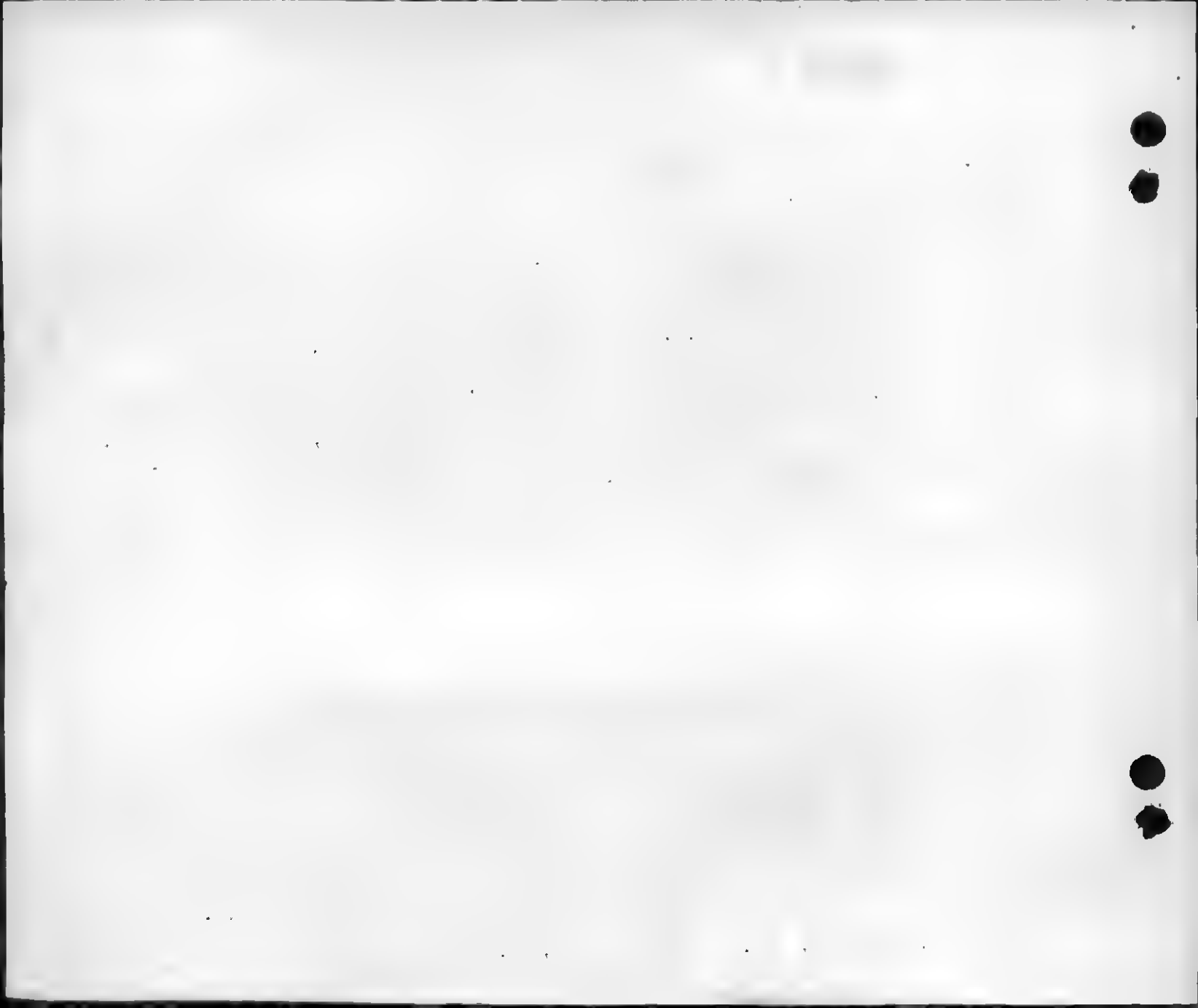
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.	
c. LENGTH OF STAY IN 1b 6/30/60-2/16/61		d. STREET ADDRESS 14428 Colesville Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAIRLAND-NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELLEN C STEWART		4. DATE OF DEATH Month 2 Day 16 Year 1961	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 26 1887
9. AGE (In years last birthday) 75		10. IF UNDER 1 YEAR: Months 9 Days 16 Hours 15 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT	
11. BIRTHPLACE (State or foreign country) Washington DC		12. CITIZEN OF WHAT COUNTRY? U-S A	
13. FATHER'S NAME Joseph Henry Crown		14. MOTHER'S MAIDEN NAME MARY FRANCES GRUBB	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Miss RACHEL CROWN		Address 14,428 Colesville Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Hypertensive Cardiovascular Disease (b) Yes (c) Yes		INTERVAL BETWEEN ONSET AND DEATH 5 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Silver Spring, Md.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1956 to 2/16 , 19 61 , that (I) (we) last saw the deceased alive on 2/10 , 19 61 , and that death occurred at 11:30 P. , from the causes and on the date stated above.			
22a. SIGNATURE C.H. Higdon		22b. DATE SIGNED 2/16/61	
22c. PHYSICIAN'S NAME (Type) C.H. Higdon		22d. ADDRESS Silver Spring, Md.	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/20/61	
23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		23d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Juka		25a. REC'D BY REGISTRAR FEB 23 '61	
25b. REGISTRAR'S SIGNATURE John L. Kenna			

I

MEDICAL CERTIFICATION



TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician.

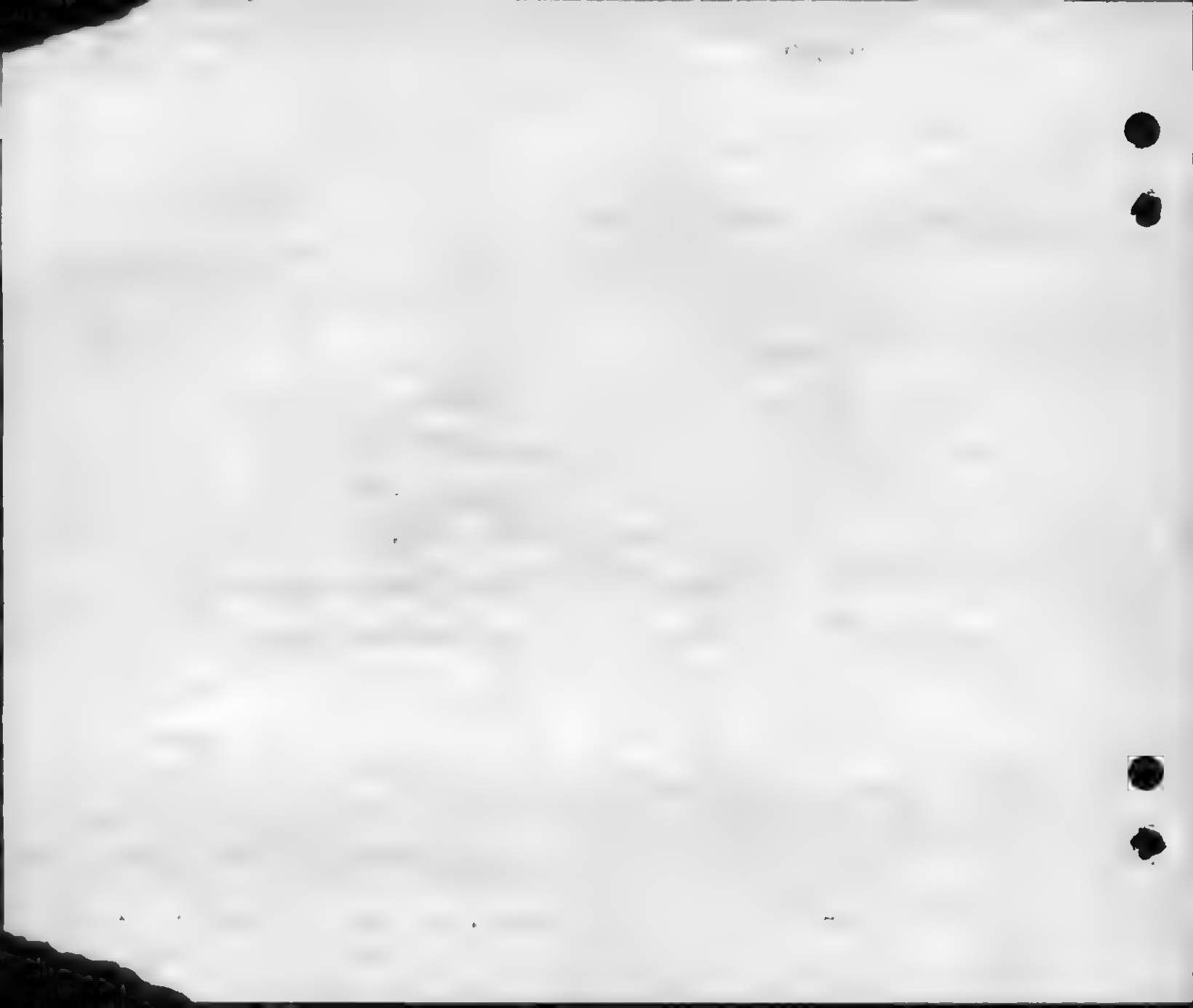
TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2169
CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN b. 9 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington
d. STREET ADDRESS 11203 Landy Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Isabel Mackey Suto
4. DATE OF DEATH February 24 1961
5. SEX Female
6. COLOR OR RACE Cauc.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 9-24-1941
9. AGE (in years last birthday) 41 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & R.N.
11. BIRTHPLACE (County & State, or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William S. Parkins
14. MOTHER'S MAIDEN NAME Mattie Sterrett
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW2
16. SOCIAL SECURITY NO. WW2
17. INFORMANT Husband-Mr. Frank Suto - same as above
18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and c)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Toxemia, septicemia
153.3 DUE TO general peritonitis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) perforated ulcerated cancer sigmoid
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). (c) Laparotomy, resection of ecto sigmoid
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐
20b. DESCRIBE HOW INJURY OCCURRED. (For nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. Month, Day, Year 19 2-15-61
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-15-61 1961, to 2-24-61, that (I) (we) last saw the deceased alive on 2-24 1961, and that death occurred at 10 PM, from the causes and on the date stated above.
22a. SIGNATURE John O. Rollen MD M.D.
22b. DATE SIGNED 2-24-61
22c. PHYSICIAN'S NAME (Type) 1015 Spring Silver Spring Md.
22d. ADDRESS
22e. MED. DIRECTOR ☒ STAFF PHYS. ☐
22f. REGISTRAR'S SIGNATURE
22g. REGISTRAR'S NAME (Type)
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 2-28-1961
23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cemetery
23d. LOCATION (City, town or county) (State) Arlington, Va.
23e. REC'D BY REGISTRAR 1750 Pa. Ave. N.W.
23f. REGISTRAR'S SIGNATURE Washington D.C.
23g. DATE FEB 28 '61



TO HOSTS: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. Broschert (Med. Examiner) notified - approved - signed a true & correct copy of this certificate

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

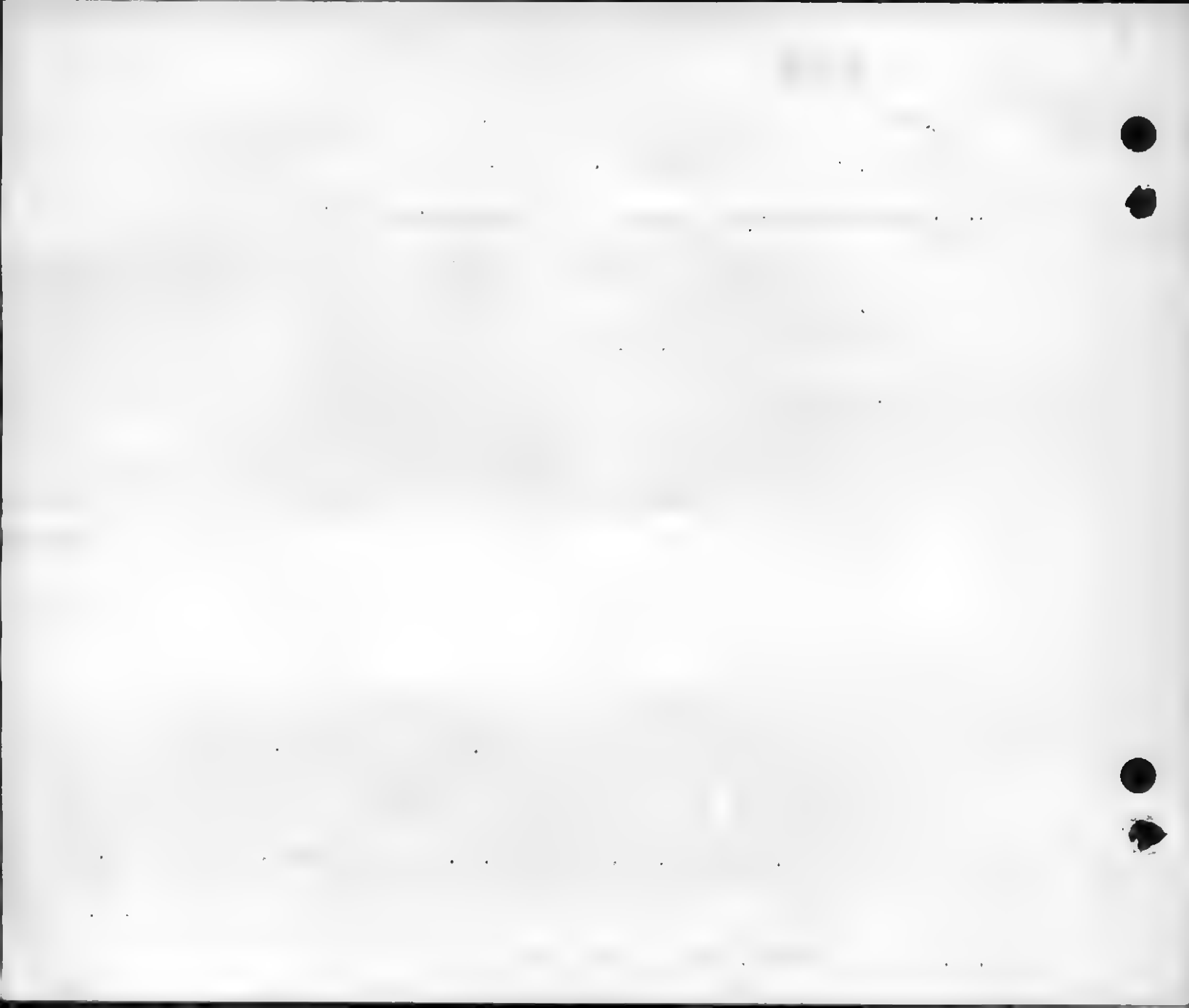
CERTIFICATE OF DEATH

2171

02148

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 18 1/2 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Victor Michael SZACIK				4. DATE OF DEATH Month Day Year February 8 19 61			
5 SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-7-61	9 AGE (In years lost birthday) yrs. 18	IF UNDER 1 YEAR Months Days 18 34	IF UNDER 24 HRS Hours Min. 18 34	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mitchell S. SZACIK				14. MOTHER'S MAIDEN NAME Nora Frances BLUME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 769.6 DUE TO prematurity. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a)) maternal diabetes; cesarean section.							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 7, 19 61 to Feb. 8, 19 61 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Feb. 8, 19 61 , and that death occurred at 9:35 AM , from the causes and on the date stated above							
22a. SIGNATURE Robert V. Rack M.D.				22b. DATE SIGNED 2-8-61		22c. PHYSICIAN'S NAME (Type) Robert V. Rack, LT, MC, USN	
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-10-61		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Washington D. C.	
24. FLNERA. DIRECTOR'S SIGNATURE R. A. Pumphrey				25a. REC'D BY REGISTRAR DATE FEB 10 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be re-examined by the medical examiner or the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2172

CERTIFICATE OF DEATH

Item 9 Film 6201 2-14-61 et

18214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>3 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>9030-Congressional Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Alexander</u> Middle <u>Thomas</u> Last <u>Thomas</u>		DATE OF DEATH Month <u>Feb.</u> Day <u>6</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-12-12</u>
9. AGE (In years last birthday) <u>48</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONSTRUCTION WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.D.</u>	
13. FATHER'S NAME <u>Wiley Thomas</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>577-40-9891</u>	
17. INFORMANT <u>CORINE (wife)</u>		Address <u>Same as above.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Empyema, Cerebral Abscess</u> DUE TO <u>493</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>pulmonary abscess,</u> DUE TO <u>pneumonia</u> (c) <u>pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>"</u> <u>" ?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>NOV. 1960</u> to <u>2-6</u> 1961, that (we) last saw the deceased alive on <u>2-6</u> 1961, and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>P. P. Andrews</u>		22b. DATE SIGNED <u>2-7-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>P. P. ANDREWS</u>		22d. ADDRESS <u>Washington 16 D. C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>2-12-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Antioch Chr. Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Skinner, Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henny S. Washington</u>		25a. REC'D BY REGISTRAR <u>4925-Dean Ave</u>	
25b. REGISTRAR'S SIGNATURE <u>715</u>		DATE <u>FEB 10 '61</u>	



TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

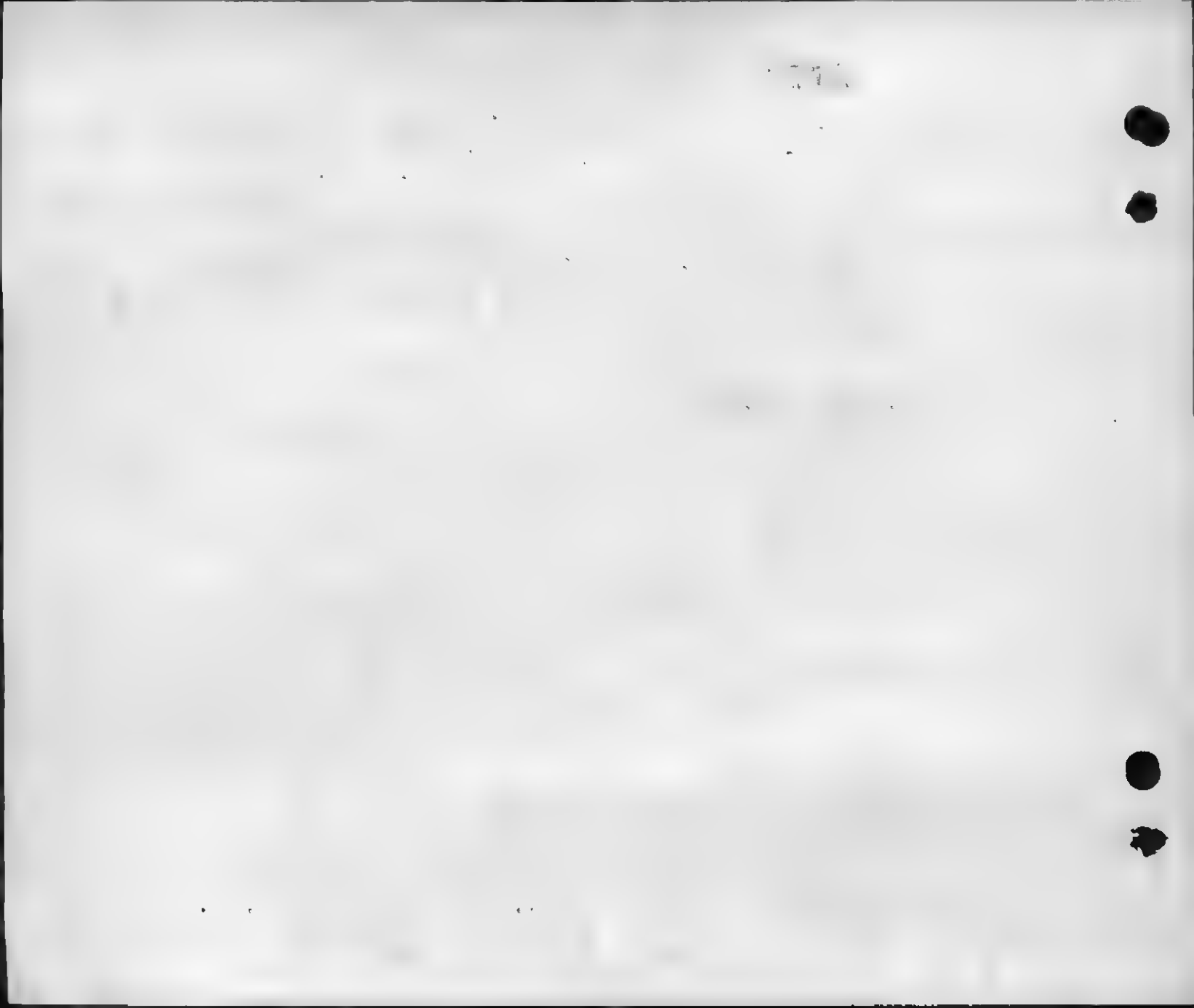
2173

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02150

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Barthesda</u> c. LENGTH OF STAY in 1b <u>3110"</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>Queen Pl. Alpine Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Baby</u> 4. SEX <u>M</u> 5. COLOR OR RACE <u>C</u> 6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 7. DATE OF BIRTH <u>Feb 22 1961</u> 8. AGE (in years last birthday) <u>3</u> yrs. <u>10</u> months <u>3</u> days <u>10</u> hours <u>10</u> min.		9. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>Willigins</u>	
13. FATHER'S NAME <u>Joseph B. Thomas</u> 14. MOTHER'S MAIDEN NAME <u>William</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> 16. SOCIAL SECURITY NO. <u>William Thomas</u> 17. INFORMATION <u>Address</u>		18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>Permativity</u> Conditions, if any, which gave rise to immediate cause (b) <u>776X</u> DUE TO <u>Permativity</u> (a), stating the underlying cause last. (c) <u>Permativity</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Permativity</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Permativity</u> 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Permativity</u> 20f. (City or town) <u>Permativity</u> (County) <u>Permativity</u> (State) <u>Permativity</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> 21. I certify that (I) (this hospital) attended the deceased from <u>2/22</u> , 19 <u>61</u> , to <u>2/22</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>2/22</u> , 19 <u>61</u> , and that death occurred <u>Permativity</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Robert L. Snowden</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>Robert L. Snowden</u> 22d. ADDRESS <u>Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2/26/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park.</u> 23d. LOCATION (City, town or county) <u>Rockville, Md.</u> (State) <u>Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u> 25a. REC'D BY REGISTRAR <u>Mar 2 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

1289x1



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2174

02151

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN TB 42 days				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine d. STREET ADDRESS Rt. 2, Box 45 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Anderson THOMAS				4. DATE OF DEATH Month Day Year February 10 1961			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-21-01	9. AGE (In years last birthday) 59 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph A. THOMAS				14. MOTHER'S MAIDEN NAME Blanche WILSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWI		17. INFORMANT (W) Mrs. Louise Thomas, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchiogenic carcinoma with metastases 1. a. i. DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 6-7 mos.	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 1961	(County) (State)			
21. I certify that (he) (this hospital) attended the deceased from Dec. 30 1961 to Feb. 10 1961 , that (he) (we) last saw the deceased alive on Feb. 10 1961 , and that death occurred at 12:20PM , from the causes and on the date stated above.							
22a. SIGNATURE F. M. Highley, Jr. M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2-10-61			
22c. PHYSICIAN'S NAME (Type) F. M. HIGHLEY, JR., LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/15/61	23c. NAME OF CEMETERY OR CREMATORY Arlington		23d. LOCATION (City, town, or county) (State) Arlington Va.			
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers		24a. ADDRESS 517 11th St. SE Wash. D.C.		25a. REC'D BY REGISTRAR FER 14 '61	25b. REGISTRAR'S SIGNATURE Wm. S. Thomas		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

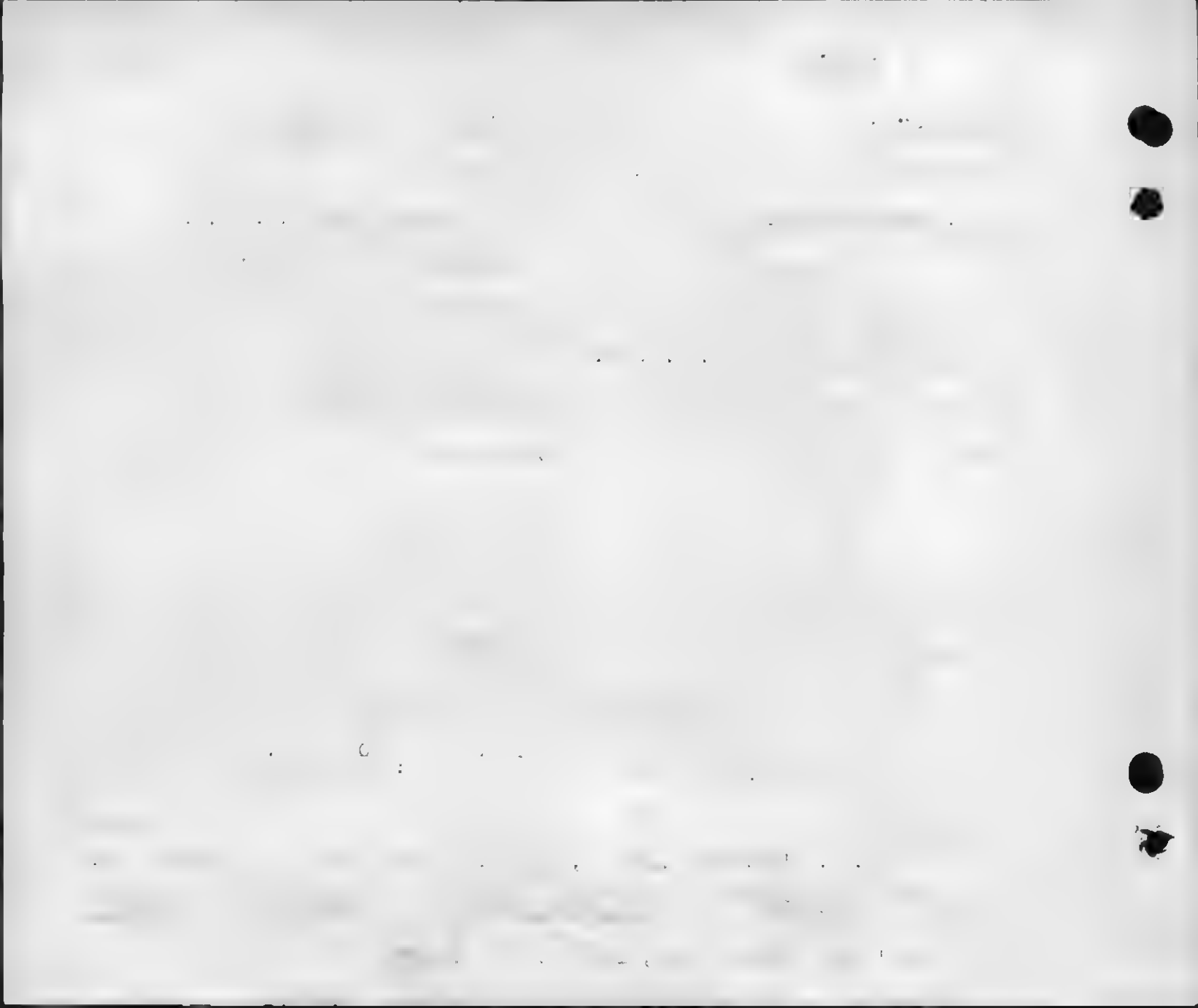
2175

CERTIFICATE OF DEATH

02152

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN b. <u>82 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1776 Pennsylvania Ave., N.W.</u> d. STREET ADDRESS <u>1776 Pennsylvania Ave., N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Clary</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>Caucasian</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>9-30-12</u> b. DATE OF DEATH <u>February 26 1961</u> c. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) <u>48 yrs.</u>		9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) <u>48 yrs.</u> 10. KIND OF BUSINESS OR INDUSTRY <u>Foreign Service Officer U. S. Govt.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward B. THOMPSON</u> 14. MOTHER'S MAIDEN NAME <u>Newell MC DUFFLE</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>1942 to 1946</u> 17. INFORMANT <u>(W) Mrs. Jessie Thompson, same as #2 above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>metastatic Carcinoma</u> Conditions, if any, which gave rise to immediate cause (b) <u>Carcinoma, stomach</u> (a), stating the underlying cause last. <u>3 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Dec. 6 1960</u> to <u>Feb. 26 1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Feb. 26 1961</u> , and that death occurred at <u>4:35 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>F. H. O'Connell</u> 22c. PHYSICIAN'S NAME (Type) <u>F. H. O'CONNELL, LCDR, MC, USN</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL <u>cremation</u> 23b. DATE THEREOF <u>2-28-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hills Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Suitland</u> <u>Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jos. Gawler's Sons Funeral Home</u> ADDRESS <u>WashDC</u>		25a. REC'D BY REGISTRAR <u>MAR 1 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

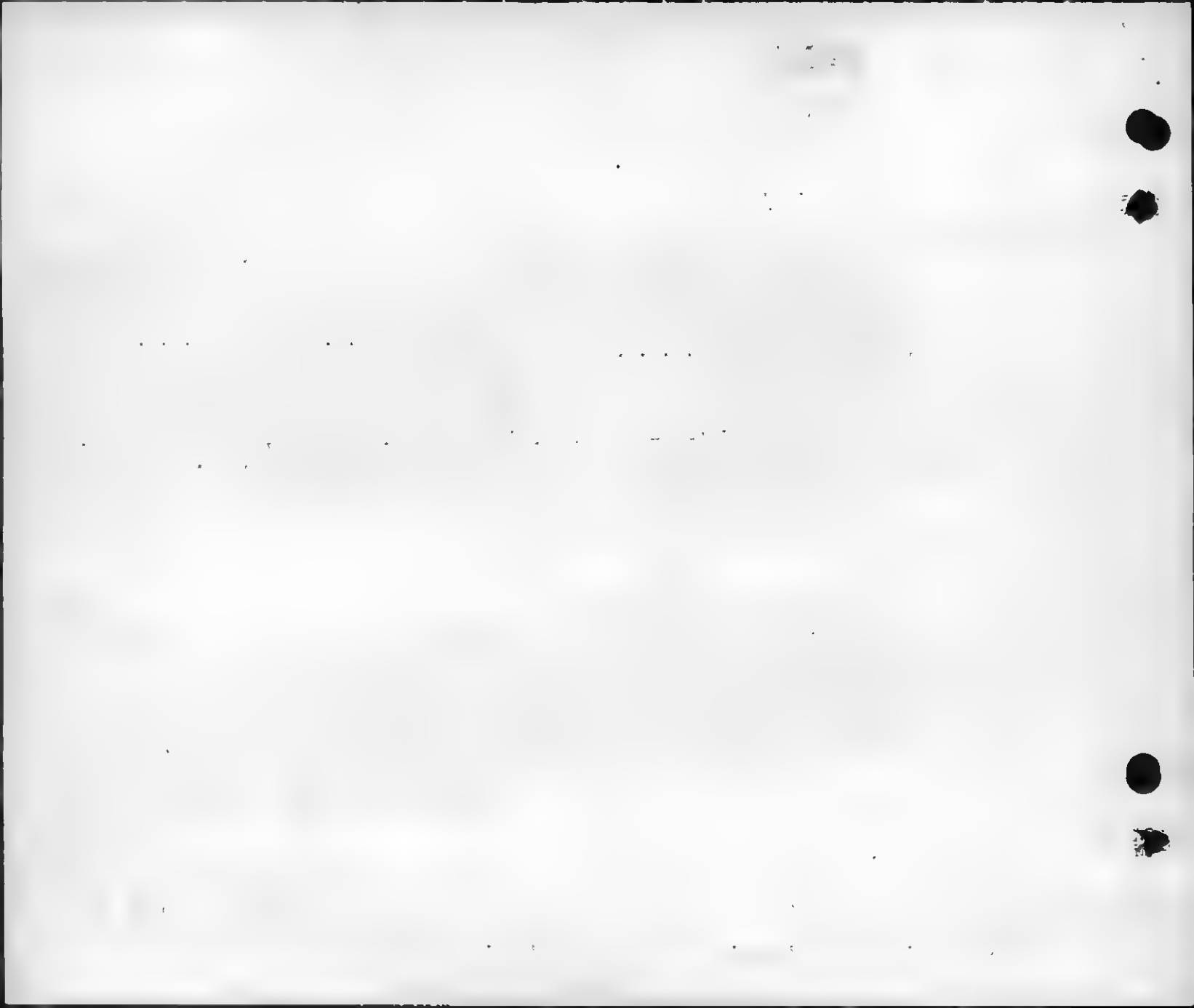
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



2176^{biv}

02153

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 4 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1006 STROUT STREET						d. STREET ADDRESS 1006 STROUT STREET			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) EMMETT FRANKLIN THOMPSON			4. DATE OF DEATH Month FEB. Day 9 Year 19 61								
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/23/95		9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building, Chief Engineer				11b. KIND OF BUSINESS OR INDUSTRY I.B.E.W.				11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN THOMPSON						14. MOTHER'S MAIDEN NAME MARY JANE MULLIN					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW #1		17. INFORMANT Mrs. Catherine C. Thompson, 1006 Strout St.		Address Silver Spring, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 422.2 IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 2-3 days	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II (a) Arteriosclerosis										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Silver Spring, Md.		(County) Montgomery		(State) Md.	
21. I certify that (I) (this hospital) attended the deceased from Feb. 1 19 61 to Feb. 9 19 61 , that (I) (we) last saw the deceased alive on Feb. 9 19 61 , and that death occurred at 11:00 M. from the causes and on the date stated above.											
22a. SIGNATURE J. Chester Brady						22b. DATE SIGNED Feb. 10 1961		22c. PHYSICIAN'S (NAME (Type)) J. CHESTER BRADY			
23a. BURIAL CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/13/61		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY				23d. LOCATION (City, town, or county) MONTGOMERY COUNTY, MARYLAND			
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Riska						25a. REC'D BY REG STRAR DATE FEB 15 '61		25b. REGISTRAR'S SIGNATURE Arthur E. Thomas			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2177

CERTIFICATE OF DEATH

Reg. Dist. No. 02154

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b 24 Yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8306 Woodhaven Blvd.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 8306 Woodhaven Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY THOMAS THOMPSON First Middle Last		4. DATE OF DEATH Month 2 Day 25 Year 19 61	
5. SEX M	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 19 98 29 19 61
9. AGE (In years last birthday) 62 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Park-Supt		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LaFayette		14. MOTHER'S MAIDEN NAME Stockdale	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Wife) ISABELLA MURRAY THOMPSON		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MALIGNANT CACITEXIA 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMATOSIS, LIVER, PERITONEUM (c) CARCINOMA, STOMACH		INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS 3 MONTHS 1 YEAR	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 19 1956 to FEBRUARY 25 1961 that I last saw the deceased alive on FEB 26 1961 and that death occurred at 7:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5009 Del Ray Ave Bethesda, Md. DATE SIGNED 2/25/61 ACTUAL SIGNATURE Robert A. Angle PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 2-27-1961		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph J. Andrews, Inc. 1756-1800		24a. REC'D BY REGISTRAR FEB 28 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Knecht			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be released by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be re-executed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
2178
MONTGOMERY
BROOKS GROVE FOUNDRY 1 yr 1 mo
OLNEY
MABEL E. TORREY
FEMALE W
HOUSEWIFE
EDWIN D. GILBY SR
ACUTE CELLULITIS LEFT FOOT
50X
JOHN B. ZIEGLER
CREMATION 2/9/61
FT. LINCOLN CREMATORY
PRINCE GEORGES, MD.
2901 14th St. N.W.
WASHINGTON 9, D.C.
FEB 10 '61
C. H. HINES

MARYLAND
VIRGINIA
ARLINGTON
5212 Little Falls Rd.
IS RESIDENCE ON A FARM? YES ☐ NO ☐

1 PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. STREET ADDRESS

3 NAME OF DECEASED
(Type or print)
First Middle Last
4. DATE OF DEATH
Month Day Year

5. SEX
6. COLOR OR RACE
7. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH
Feb 16, 1874
9. AGE (In years lost birthday) yrs
86
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
11. BIRTHPLACE (State or foreign country)
Maine
12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
16. SOCIAL SECURITY NO.
17. INFORMANT
Edwin D. Gilby SR
5235
Arlington, Va.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute cellulitis left foot
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) weak circulation and hemorrhage
DUE TO
(c) foot inflammation
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☐

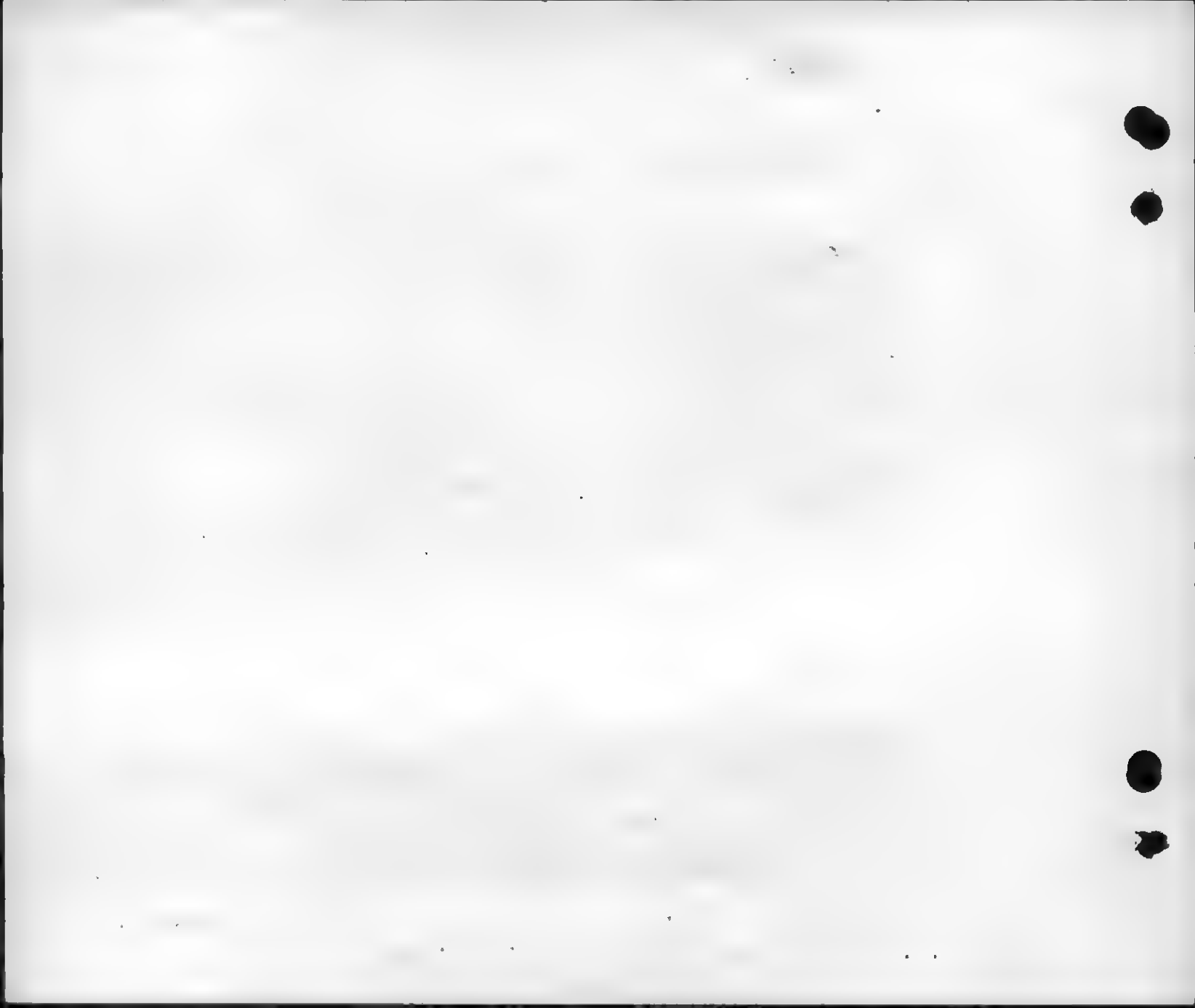
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
19
20d. INJURY OCCURRED
While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Jan 8, 1961, to Feb 7, 1961, that (I) (we) last saw the deceased alive on Feb 7, 1961, and that death occurred at 2:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS
22e. REC'D BY REGISTRAR
22f. REGISTRAR'S SIGNATURE

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE
The S.H. Hines Company
25a. REC'D BY REGISTRAR
25b. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

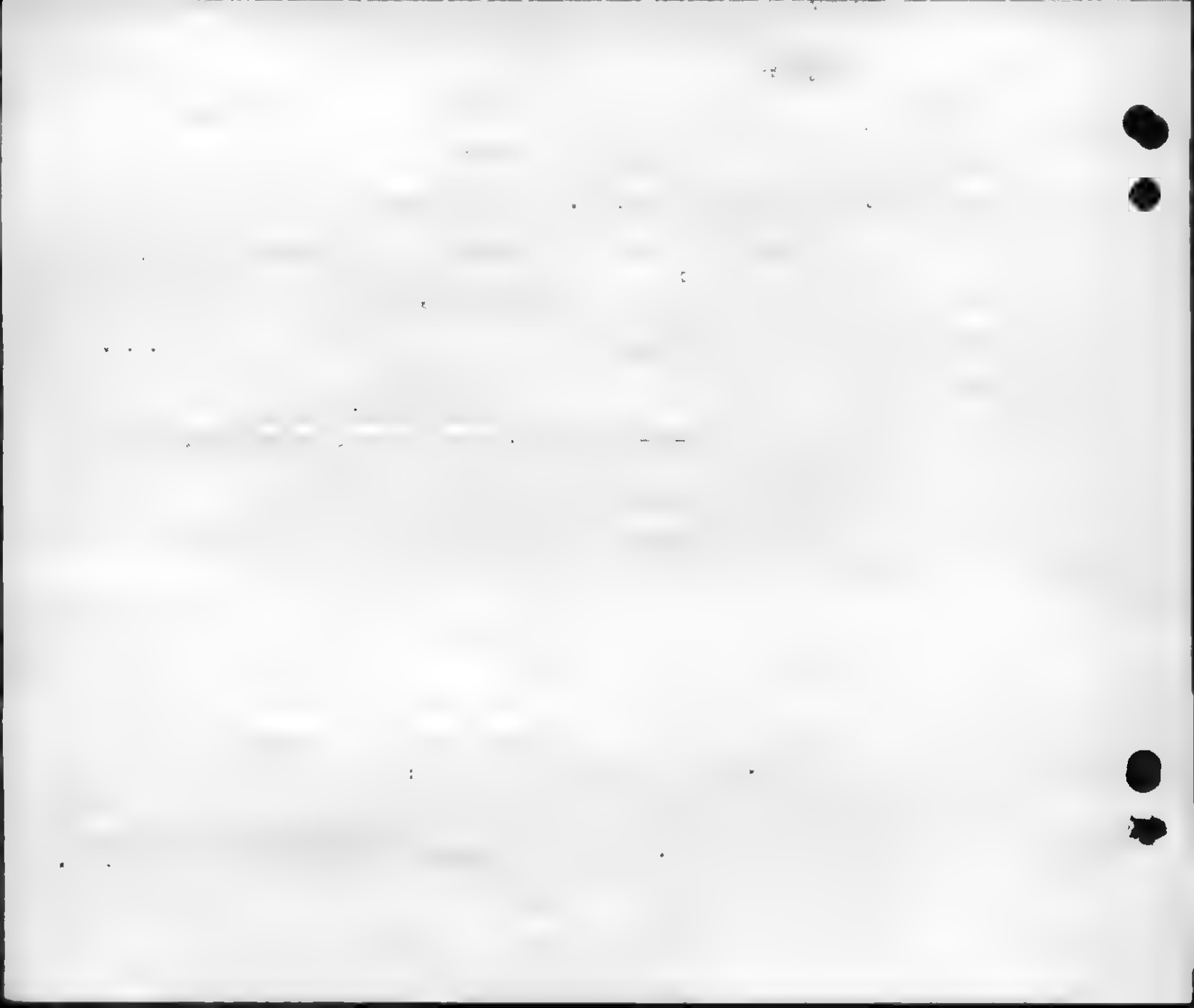
2179

CERTIFICATE OF DEATH

02156

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS 9212 Bardon Road			
3. NAME OF DECEASED (Type or print) First Herman Middle (None) Last Tuckman				4. DATE OF DEATH Month February Day 17 Year 19 61			
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 20, 1901	
9 AGE (In years last birthday) 59		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder		10b. KIND OF BUSINESS OR INDUSTRY Construction		11 BIRTHPLACE (State or foreign country) Poland	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Harry Tuckman		14. MOTHER'S MAIDEN NAME Sarah Wolman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-40-1944		17 INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia Gram and Organism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Colon, Metastasis to liver and lungs DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 48 Hours 8 Hours						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from February 13, 19 61 to February 17, 19 61 , that (I) (we) last saw the deceased alive on Feb. 17, 19 61 , and that death occurred at 2:15 PM from the causes and on the date stated above.							
22a. SIGNATURE <i>Walter Opelt</i>				22b. DATE SIGNED 2/17/61			
22c. PHYSICIAN'S NAME (Type) Walter Opelt M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL CREMATION, REMOVAL (Spec. fy) Burial		23b. DATE THEREOF 2/19/1961		23c. NAME OF CEMETERY OR CREMATORY MT. Lebanon Cem.		23d. LOCATION (City, town, or county) (State) Hyattsville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons				25a. REC'D BY REGISTRAR WASH. D.C.			
25b. REGISTRAR'S SIGNATURE <i>Charles S. Kenna</i>				DATE FEB 21 '61			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

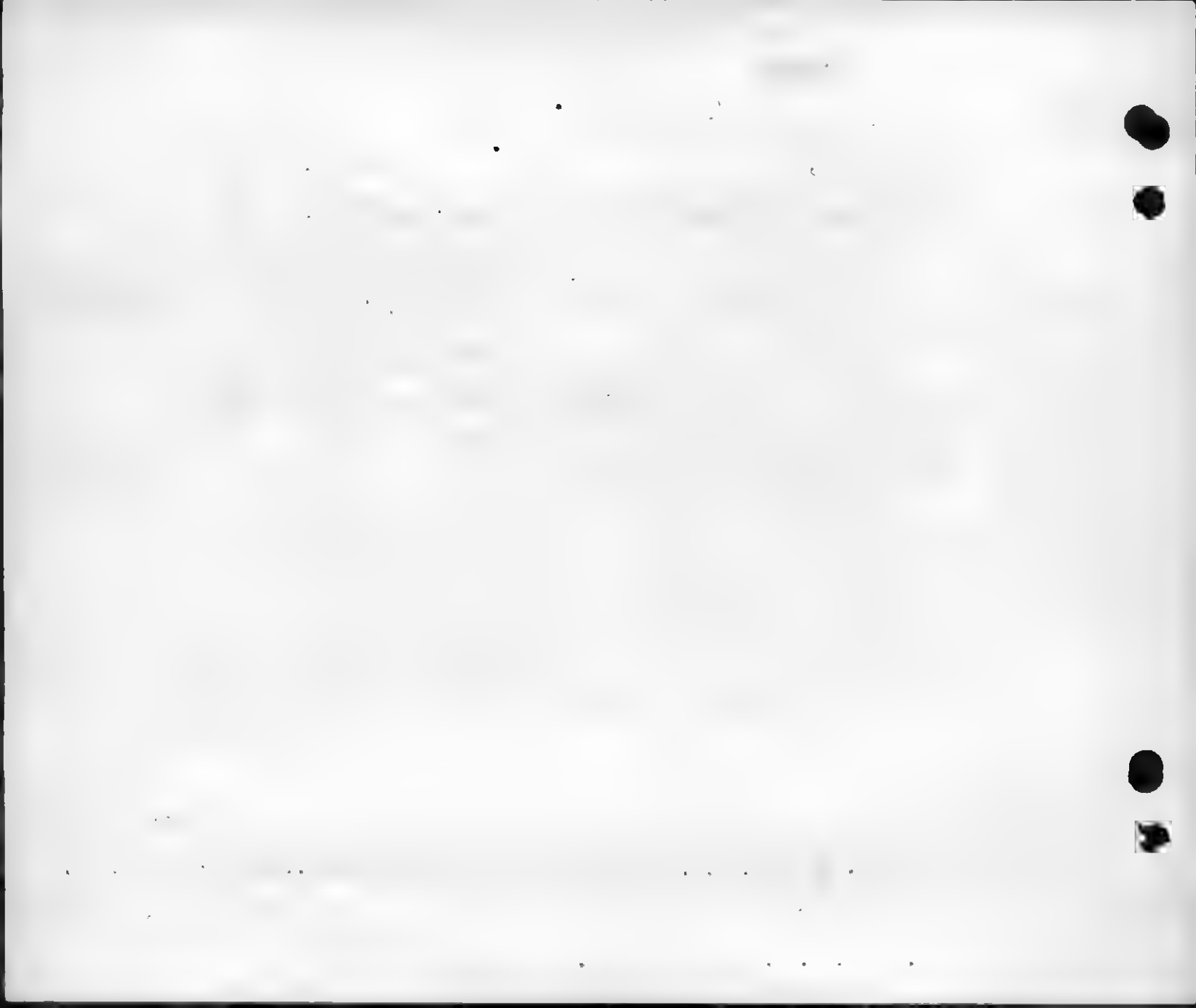
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02157

2180

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Warrell				4. DATE OF DEATH Month Day Year February 25, 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 24, 1961	
9. AGE (In years last birthday) 6		10. IF UNDER 1 YEAR Months Days 6 55		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none			
13. FATHER'S NAME Carroll Gene Warrell				14. MOTHER'S MAIDEN NAME Virginia Lee Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) no		17. INFORMANT Address father			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH 12 hrs.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that James R. Coleman M.D. (this hospital) attended the deceased from 2/24, 1961 to 2/25, 1961 , that (1) (we) last saw the deceased alive on 2/24, 1961 , and that death occurred at 2:45 A.M. from the causes and on the date stated above.							
22a. SIGNATURE James R. Coleman M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-25-61			
22c. PHYSICIAN'S NAME (Type) James R. Coleman, M.D.		22d. ADDRESS 733 Sligo Ave., Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 2-26-61		23c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium & Hospital, Takoma Park, Maryland		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M. D. Washington San. & Hospital				25a. REC'D BY REGISTRAR FEB 28 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

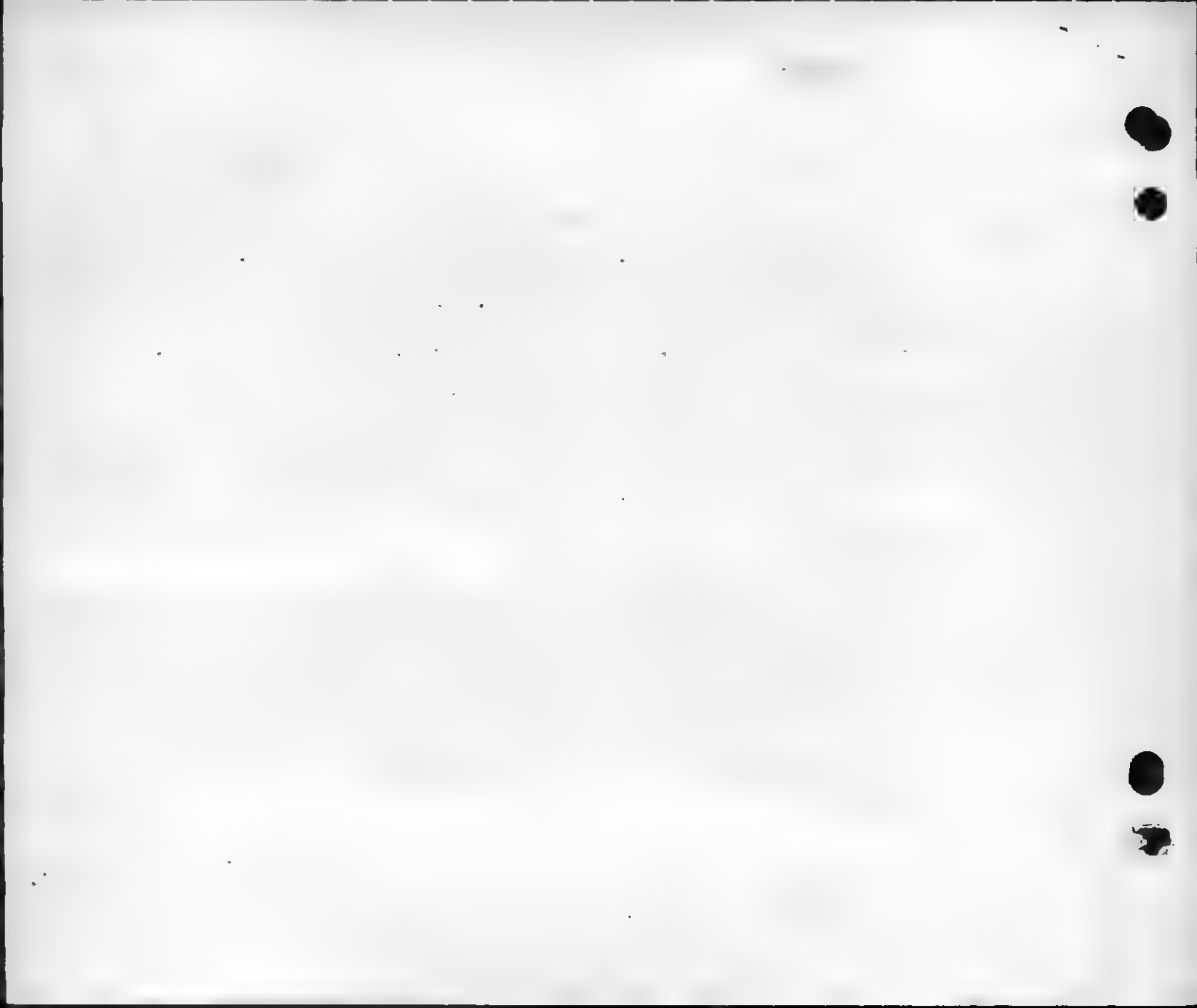
2181

CERTIFICATE OF DEATH

02158

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairland (Rural)				c. LENGTH OF STAY IN lb 6 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First ALBURN Middle H. Last WATKINS				4 DATE OF DEATH Month Feb. Day 2, Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 6, 1861	
9. AGE (In years lost birthday) 99		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min		12. CITIZEN OF WHAT COUNTRY? U. S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Guard				10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Joshua Watkins				14. MOTHER'S MAIDEN NAME Mary Ann Beal			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Flossie Dodson-daughter-same 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 50.0 Congestive heart failure DUE TO (b) Generalized arteriosclerosis DUE TO (c) Generalized arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 2, 1961 to Feb. 2, 1961 , that (I) (we) last saw the deceased alive on Jan. 30, 1961 , and that death occurred at AM from the causes and on the date stated above							
22a. SIGNATURE A. F. Thibadeau				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) A. F. THIBADEAU				22d. ADDRESS 10111 Colesville Rd., Silver Spring Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/5/61		23c. NAME OF CEMETERY OR CREMATORY Beth. Meth. Church Cem		23d. LOCATION (City, town, or county) (State) Browningsville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				25a. REC'D BY REGISTRAR BETHESDA, Maryland		25b. REGISTRAR'S SIGNATURE Feb 3 '61	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be returned to the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed in 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

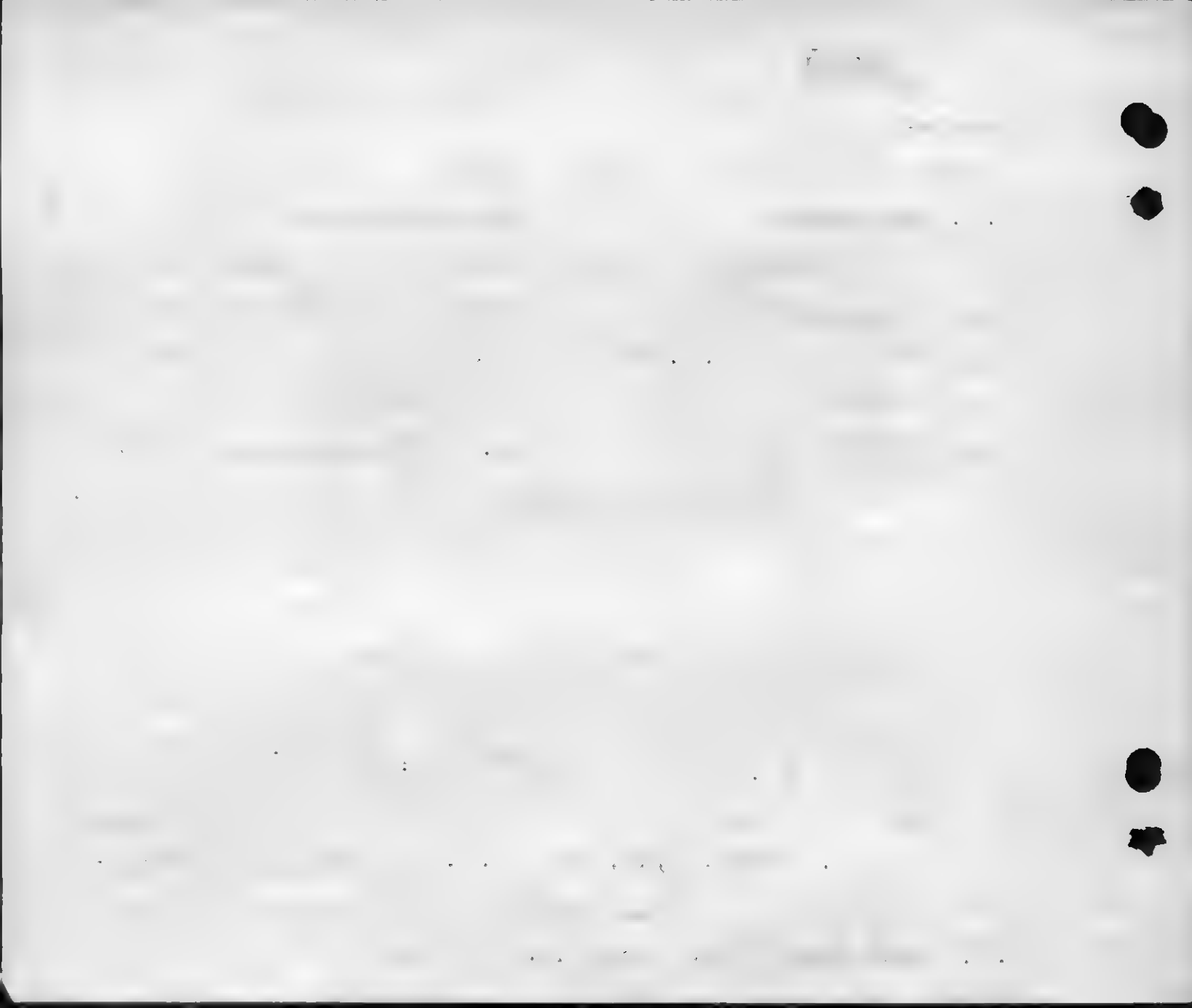
VR A15 (4)
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051

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural) c. LENGTH OF STAY IN b 207 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Florida b. COUNTY Orlando c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5701 Yucatan Drive d. STREET ADDRESS 5701 Yucatan Drive	
3. NAME OF DECEASED (Type or print) Richmond Willey WATKINS		4. DATE OF DEATH Month Day Year February 27 1961	
5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 10-15-03	
9. AGE (In years, last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 57 yrs.	
10a. USUA. OCCUPAT ON (Give kind of work done during most of working life, even if retired) Officer U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY California	
11. BIRTHPLACE USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William WATKINS		14. MOTHER'S MAIDEN NAME Nellie SHEPHERD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 1916 to 1946		16. SOCIAL SECURITY NO. (W) Mrs. Anne Watkins, same as #2 above	
17. INFORMANT (W) Mrs. Anne Watkins, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic adenocarcinoma, primary unknown DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 9 mos.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.] 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that 10 (this hospital) attended the deceased from August 4, 1960 to Feb. 27, 1961 , that 10 (we) last saw the deceased alive on Feb. 27, 1961 , and that death occurred at 12:02PM M, from the causes and on the date stated above.			
22a. SIGNATURE Joseph E. Stitcher 22b. PHYSICIAN'S NAME (Type) J. E. STITCHER, LT, MC, USN		22c. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-2-61	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey 24b. ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR DATE MAR 2 '61	
25b. REGISTRAR'S SIGNATURE C. S. Kline			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2183

CERTIFICATE OF DEATH

02160

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Leonard Middle Way Last Way		4. DATE OF DEATH Month February Day 6 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 4, 1877
9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR Months 4 Days 2 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY ICC examiner	
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) no		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Jessie Way (Wife)		Address As above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Asystole of the heart Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Adams - Stokes syndrome (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 5 min 4 months 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from October 1960 to February 6, 1961 , that (I) (we) last saw the deceased alive on Feb 5 19 61 , and that death occurred at 12:01 M, from the causes and on the date stated above			
22a. SIGNATURE Thomas F. O'Connor		22b. DATE SIGNED 2/6/61	
22c. PHYSICIAN'S NAME (Type) THOMAS F. O'CONNOR		22d. ADDRESS 4801, Battery Lane, Bethesda, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-9-61	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR FEB 9 '61	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Charles E. Pumphrey	

Page 4 of 4
ING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. It may be returned to the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

2184

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02161

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>1300 Jonquil St. N.W.</u> d. STREET ADDRESS <u>Washington</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louise Elizabeth Wayson</u> 4. SEX <u>Female</u> 5. COLOR OR RACE <u>White</u> 6. MARRIED <input checked="" type="checkbox"/> EVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>Feb. 20, 1907</u> 7. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. AGE (In years last birthday) <u>57</u> yrs. 9. UNDER 1 YEAR <u>15</u> Months <u>15</u> Days <u>19</u> Hours <u>61</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13. FATHER'S NAME <u>HARRY Tabb</u> 14. MOTHER'S MAIDEN NAME <u>Grace Rolland</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT <u>Hospital records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (e) <u>Myocardial Failure</u> (b) <u>Myocardial infarction</u> (c) <u>6 hrs.</u> DUE TO <u>6 hrs.</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)</u>			
20c. TIME OF INJURY Month, Day, Year <u>Feb. 8, 1961</u> Hour a.m. <u>19</u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>20f. (City or town) (County) (State)</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 8, 1961</u> to <u>Feb. 15, 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb. 15, 1961</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Lyste William</u> M.D. 22b. DATE SIGNED <u>Feb. 15, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>Lyste William</u> 22d. ADDRESS <u>8700 Colosville Rd - Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL, or Special <u>burial</u> 23b. DATE THEREOF <u>2/18/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thos H Hines</u> ADDRESS <u>2901-14th St NW</u> 25a. REC'D BY REGISTRAR <u>FEB 20 1961</u> 25b. REGISTRAR'S SIGNATURE <u>William S. Hines</u>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Montgomery Co. Deputy Medical Examiner notified and released to hospital,

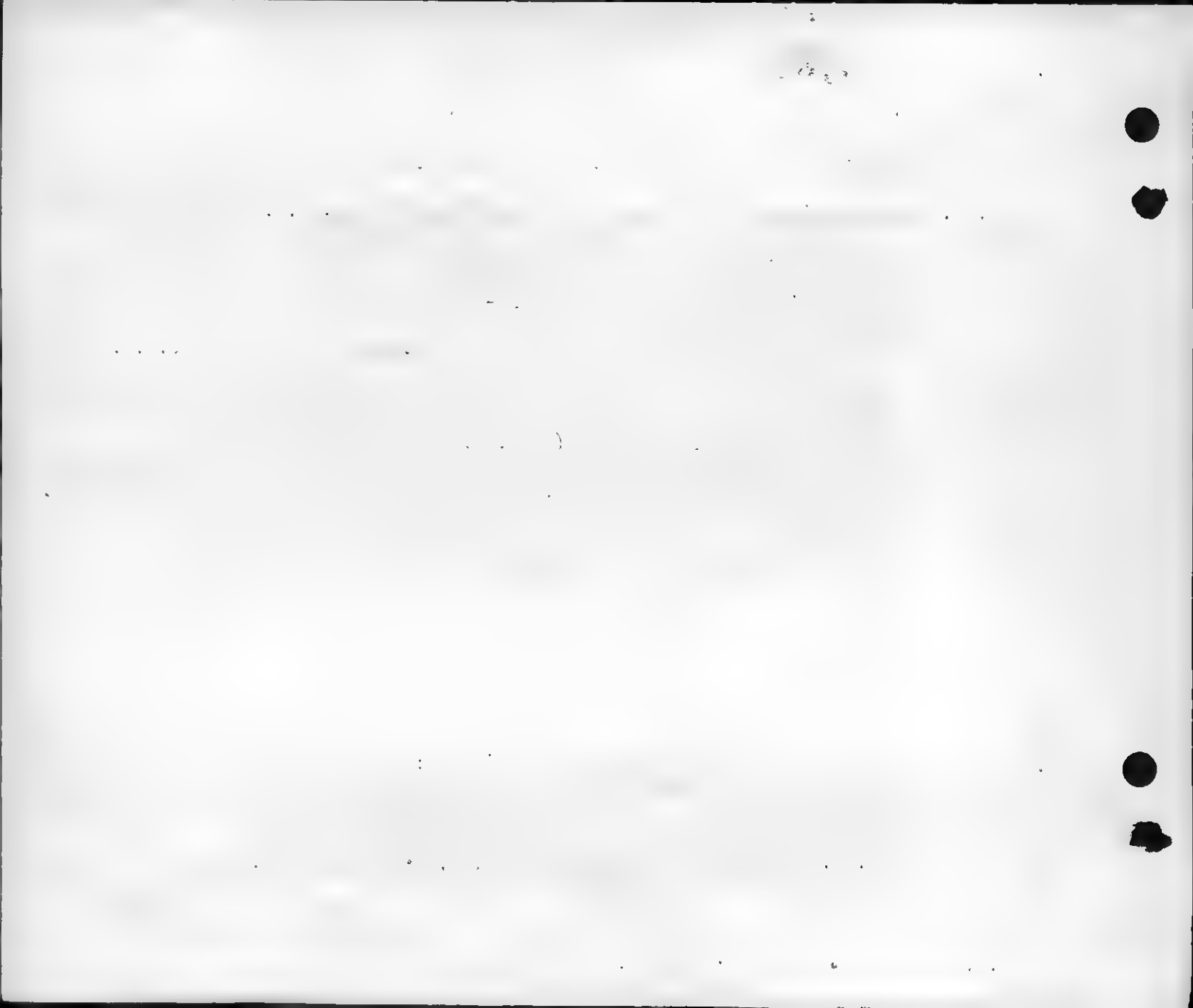
VR A15 (4)
15M 9/59

2185

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02162

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 12 hrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 208 Wayne Place, S.E., Apt. 201 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3 NAME OF DECEASED (Type or print) First Dorothea Middle Yates Last WEEKS		4. DATE OF DEATH Month February Day 3 Year 19 61				
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12-18-26	9. AGE (In years last birthday) 34 yrs	IF UNDER 1 YEAR Months 3 Days 19 Hours 61	IF UNDER 24 HRS Mn.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Raymond YATES			14. MOTHER'S MAIDEN NAME Edna			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO 415-32-0316		17. INFORMANT (H) G. J. Weeks, same as #2 above Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage, intracerebral, spontaneous 531X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) (City or town) (County) (State)		
21 I certify that (this hospital) attended the deceased from Feb. 2, 1961, 4:50AM to Feb. 3, 1961 that (we) last saw the deceased alive on Feb. 3, 1961 , and that death occurred at M , from the causes and on the date stated above						
22a. SIGNATURE F. H. GILLES, LT, MC, USNR		22b. ADDRESS U. S. Naval Hospital, Bethesda, Md.		22c. DATE SIGNED 2-4-61		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipments		23b. DATE THEREOF 2-4-61		23c. NAME OF CEMETERY OR CREMATORY Knoxville Tenn.		
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers		ADDRESS WashDC		25a. REC'D BY REGISTRAR FEB 8 '61		
25b. REGISTRAR'S SIGNATURE Christina S. Kraus						



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

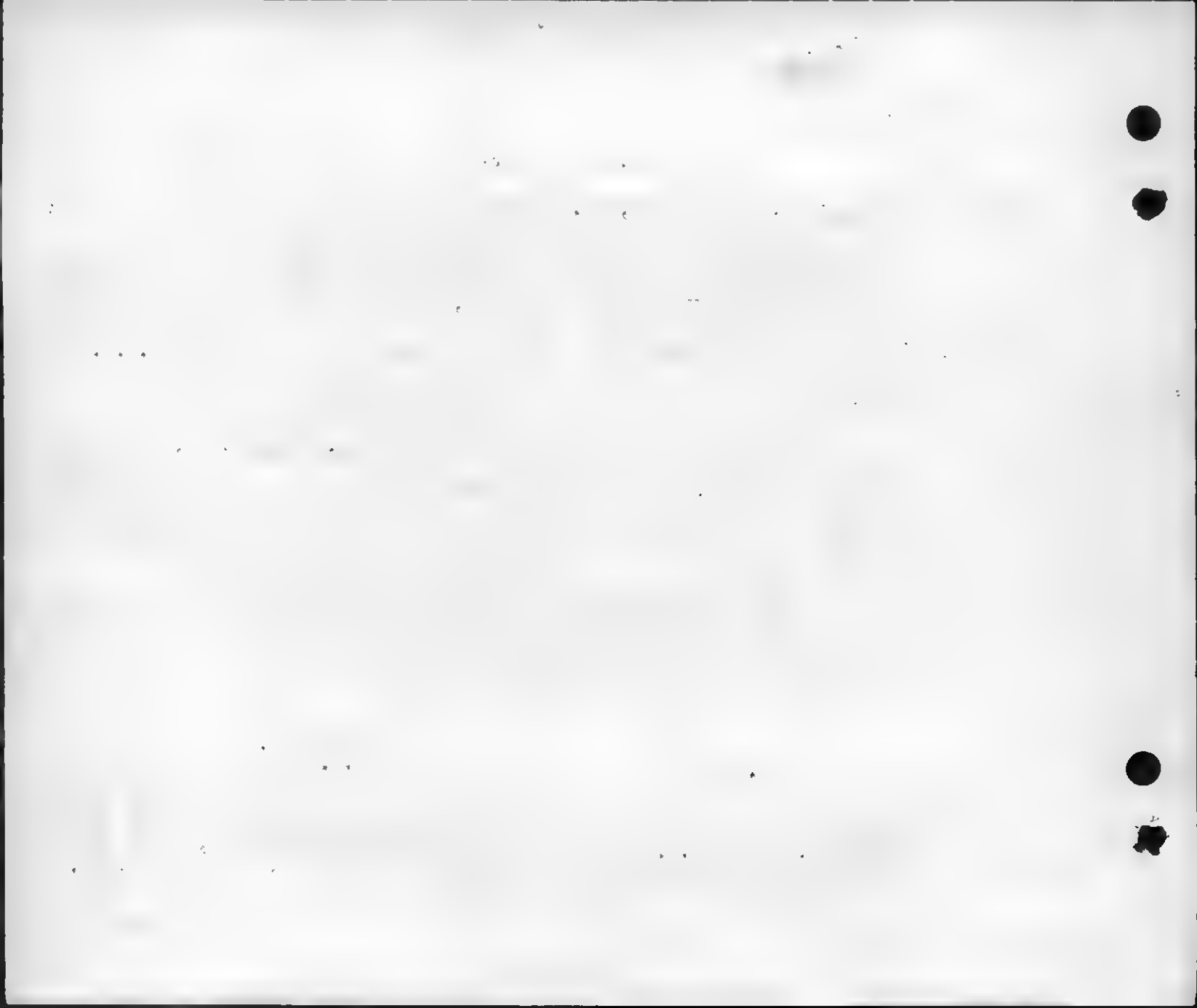
02163

2186

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Virginia b. COUNTY Amherst		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monroe		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS Route # 2		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Sadie Mae Wells			4. DATE OF DEATH Month Day Year February 22 19 61		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH May 27, 1902		9. AGE (In years last birthday) 58 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurses Aide		10b. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Delaware Goolsby		14. MOTHER'S MAIDEN NAME Blanche Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Unascertainable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoid Syndrome 152.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Primary site ileum DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH 4 years					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o m. p m 19					
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from January 25 19 61 to February 22 19 61 , that (I) (we) last saw the deceased alive on Feb. 22 19 61 , and that death occurred at 8:05 p.m. from the causes and on the date stated above.					
22a. SIGNATURE John A. Oates, M.D. M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> 22b. DATE SIGNED 2/23/61					
22c. PHYSICIAN'S NAME (Type) JOHN A. OATES, M.D. 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-25-61		23c. NAME OF CEMETERY OR CREMATORY Davis Cemetery, Shipman, Va.	
23d. LOCATION (City, town, or county) (State) Shipman, Va.		24. FUNERAL DIRECTOR'S SIGNATURE H. H. Demaingo		ADDRESS Alex, Va.	
25a. REC'D BY REGISTRAR DATE 2 7 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



2187

CERTIFICATE OF DEATH

Reg. Dist. No.

02164

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING KENSINGTON		c. LENGTH OF STAY IN lb 56 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VIER'S MILL ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last JOSEPH WILLIAM WILDMAN		4. DATE OF DEATH Month Day Year FEB. 3 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/21/69
9. AGE (In years last birthday) 91		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Carpenter & builder (retired)		10b. KIND OF BUSINESS OR INDUSTRY VIRGINIA	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BURR WILDMAN		14. MOTHER'S MAIDEN NAME ELIZABETH LOVELESS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 579-10-1841	
17. INFORMANT Mr. Mason W. Wildman, Viers Mill Rd. Kensington, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation 3-21X DUE TO Cerebral Vascular accident (stroke) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) 10 weeks (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1957 to Feb 3 1961, that I last saw the deceased alive on Jan 31 1961, and that death occurred at 1 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE John H. Andrews		ADDRESS (Street, city or town, state) 960 Colver Rd. Silver Spring Md. DATE SIGNED Feb 3-1961	
PHYSICIAN'S NAME (Type) John H. Andrews		DATE SIGNED Feb 3-1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/7/61	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Gaska		24a. REC'D BY REGISTRAR DATE FEB 9 '61	
24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the registrar or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be revised by a physician or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2188

02165

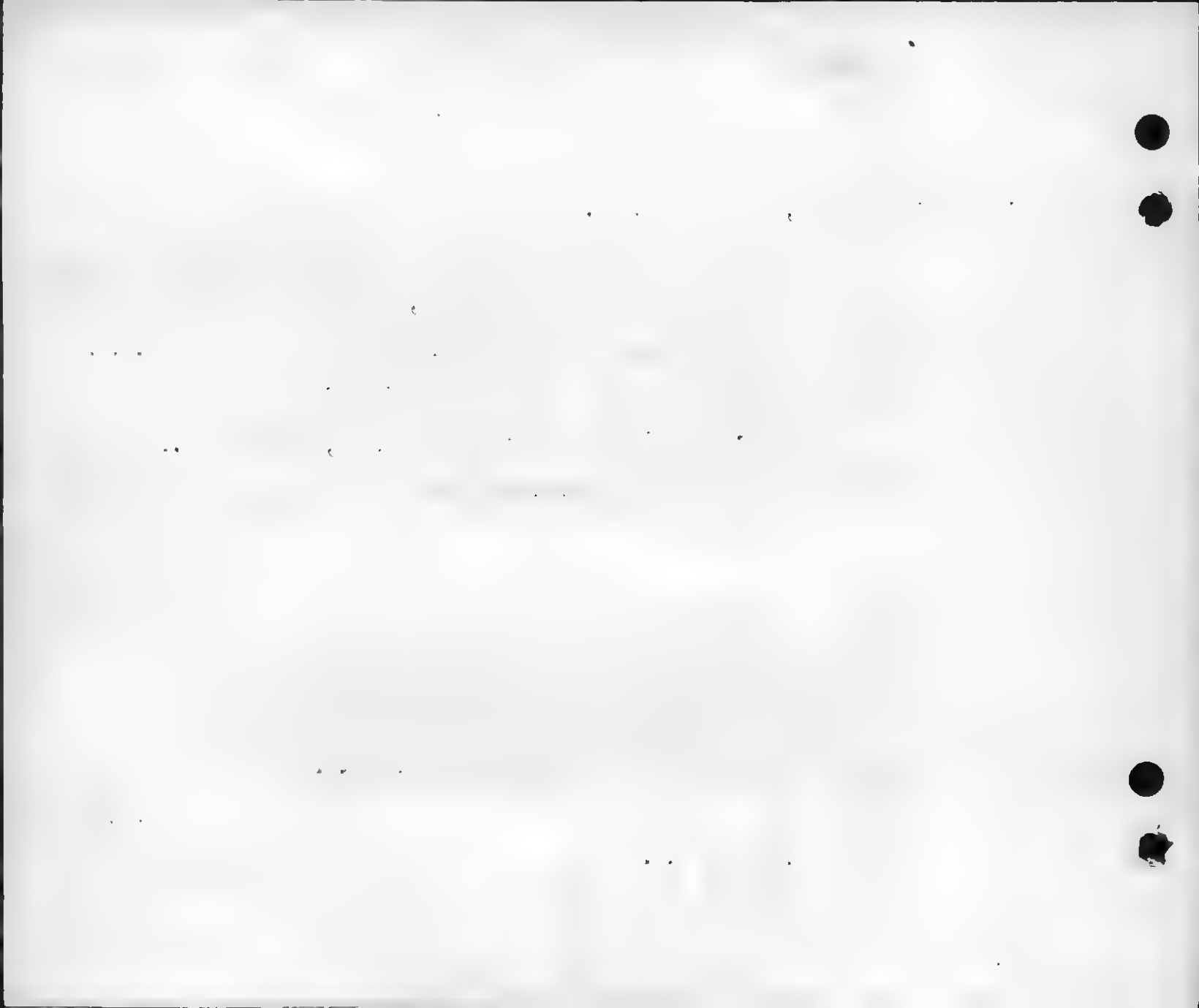
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 67 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS Star Route, Box 29			
3. NAME OF DECEASED (Type or print) First Faye Middle Elizabeth Last Wiley				4. DATE OF DEATH Month February Day 28 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 12, 1915	
9. AGE (In years last birthday) 46 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) Store Clerk				10b. KIND OF BUSINESS OR INDUSTRY Store		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Edwards				14. MOTHER'S MAIDEN NAME Martha Ann Fine			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO Unascertainable		17. INFORMANT The Medical Records The Clinical Center, Bethesda 14., Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myelogenous Leukemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 4 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from December 23, 1960 to February 28, 1961 , that (I) (we) last saw the deceased alive on February 28, 1961 and that death occurred at 11:20 p.m. from the causes and on the date stated above.							
22a. SIGNATURE Edward E. Morse M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/1/61	
22c. PHYSICIAN'S NAME (Type) EDWARD E. MORSE, M.D.				22d. ADDRESS The Clinical Center National Institutes of Health Bethesda 14, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/3/61		23c. NAME OF CEMETERY OR CREMATORY MT TABOR CEMETERY		23d. LOCATION (City, town, or county) (State) Beckley W. Va	
24. FUNERAL DIRECTOR'S SIGNATURE W W Chambers				ADDRESS 1400 Chapin St. N.W.		25a. REC'D BY REGISTRAR DATE MAR 3 '61	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kins	
WASHINGTON D.C.							

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND.

2189

CERTIFICATE OF DEATH

02166

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN b. <u>45 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON SANITARIUM AND HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> d. STREET ADDRESS <u>7120 PINEY BRANCH ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>Dorothy</u> e. COLOR OR RACE <u>White</u> f. SEX <u>Female</u>		4. DATE OF DEATH a. DATE OF BIRTH <u>11-1-88</u> b. DATE OF DEATH <u>Feb 2 1961</u> c. AGE (In years last birthday) <u>72 yrs.</u> d. IF UNDER 1 YEAR: Months <u>2</u> Days <u>2</u> Hours <u>19</u> Min. <u>61</u> e. IF UNDER 24 HRS.: Hours <u>19</u> Min. <u>61</u>	
5. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 6. KIND OF BUSINESS OR INDUSTRY <u>District of Columbia</u> 7. BIRTHPLACE (County & State, or foreign country) <u>U.S.</u> 8. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		9. FATHER'S NAME <u>FRANK Hovvis</u> 10. MOTHER'S MAIDEN NAME <u>Elizabeth Neshe</u> 11. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 12. SOCIAL SECURITY NO. <u>11-1-88</u> 13. INFORMANT <u>WASHINGTON SANITARIUM and Hospital Records</u>	
14. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the uterus</u> DUE TO (b) <u>174</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>174</u> DUE TO (c) <u>174</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>174</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 years</u>			
15. MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY: Month, Day, Year <u>Nov 10 1958</u> Hour a.m. <u>19</u> p.m. <u>19</u> 20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. IC ty or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 10 1958</u> to <u>Feb 2 1961</u> that (I) (we) last saw the deceased alive on <u>Feb 1 1961</u> and that death occurred at <u>10 AM</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Arthur W. Danish</u> 22b. DATE SIGNED <u>2-2-61</u> 22c. PHYSICIAN'S NAME (Type) <u>ABRAHAM W. DANISH</u> 22d. ADDRESS <u>927 PERSHING DR</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Feb 5, 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Prince George Co., Md.</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur W. Danish</u> 25. REC'D BY REGISTRAR <u>FEB 6 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>			

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
15M 9/60

11-11-11



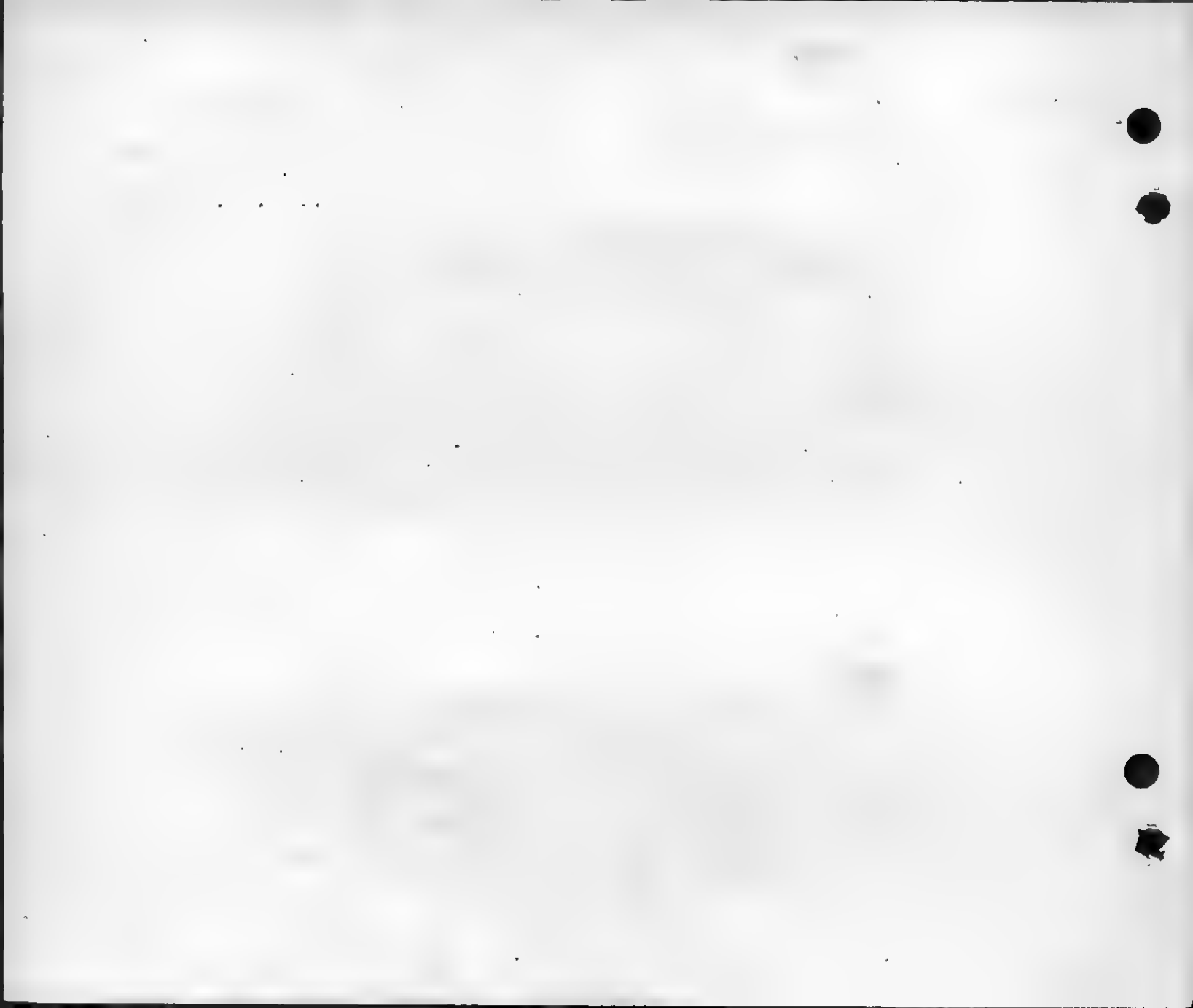
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

2100
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02167

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Columbia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens</u>		d. STREET ADDRESS <u>3221 Oliver St., N. W.</u>	
3. NAME OF DECEASED (Type or print) <u>Lucille</u> First <u>Dutton</u> Middle <u>Williams</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23, 1885</u>
9. AGE (In years lost birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Cleveland Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Mr. Kenneth J. Dutton</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Billmeyer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Daughter - 3221 Oliver St.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterial Thrombosis, all left leg & thigh and rt leg</u> 4 4 4X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, severe, general</u> DUE TO (c) <u>Essential Hypertension, severe</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>10 yrs +</u> <u>10 yrs +</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Old left hemiplegia, severe</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>			
20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Feb 14, 1961</u> to <u>Feb 14, 1961</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Feb 14, 1961</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Stewart Clapp</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>2.15.61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u> 22d. ADDRESS <u>4740 Chevy Chase Dr Chevy Chase Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-16-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		25a. REC'D BY REGISTRAR <u>Bethesda, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>		DATE <u>FEB 17 '61</u>	



2191

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02168

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 8 hrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Virginia b. COUNTY Vienna c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna d. STREET ADDRESS 305 Roosevelt Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Una Elizabeth WOLFE				4. DATE OF DEATH Month Day Year February 6 1961			
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-2-86	9. AGE (In years last birthday) 74 yrs	10. UNDER 1 YEAR Months Days 74	11. UNDER 24 HRS Hours Min 74	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard D. MC Mellen			14. MOTHER'S MAIDEN NAME Madeline E. KNOTT				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO - - - - -		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary artery arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 days						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Vienna	(County) Stafford	(State) Virginia		
21. I certify that U (this hospital) attended the deceased from Feb. 6 1961 to Feb. 6 1961 , that U (we) last saw the deceased alive on Feb. 6 1961 , and that death occurred at 3:50 PM , from the causes and on the date stated above.							
22a. SIGNATURE William P. Baker		M D William P. Baker, Lt., MC, USN		22b. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS					
23a. BURIAL CREMATION, REMOVAL (Specify) Burial-Shipment 2-8-61		23b. DATE THEREOF 2-8-61		23c. NAME OF CEMETERY OR CREMATORY Municipal Cemetery		23d. LOCATION (City, town, or county) (State) Aransas Pass Texas	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey R. A. Humphrey Funeral Home, Bethesda, Md.				25a. REC'D BY REGISTRAR DATE FEB 9 '61		25b. REGISTRAR'S SIGNATURE Charles S. House	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02169

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN lb 56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. STREET ADDRESS 4511 Willard Ave.	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CLAUDE Middle H. Last WOODWARD		4. DATE OF DEATH Month Feb. Day 8, Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, 1877
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 2 Days 26	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Washington, D. C.	
11. BIRTHPLACE (State or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Wallace Woodward		14. MOTHER'S MAIDEN NAME Ella Simmons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-12-2357	
17. INFORMANT Daughter		Address Mrs. Mildred Shoemaker - Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Uremia & congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial infarction and DUE TO arteriosclerotic heart and kidneys (c) 		INTERVAL BETWEEN ONSET AND DEATH 3 days 16 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1939 to Feb 8, 1961 , that (I) (we) last saw the deceased alive on Feb 7, 1961 , and that death occurred at 22 M. from the causes and on the date stated above.			
22a. SIGNATURE Gilbert B. Rude		22b. DATE SIGNED Feb. 8, 1961	
22c. PHYSICIAN'S NAME (Type) Gilbert B Rude.		22d. ADDRESS 3900 Military rd N.W.DC.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-11-61	
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
25a. REC'D BY REGISTRAR FEB 14 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

3105

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2193
CERTIFICATE OF DEATH

02170

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 14 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Georgia Middle Inez Last Young		4. DATE OF DEATH Month February Day 7 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27, 1887
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Georgia	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Lowe		14. MOTHER'S MAIDEN NAME Sarah Stead	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Not Available	
17. INFORMANT The Medical Record,		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pseudomonas aeruginosa septicemia DUE TO (b) Multiple myeloma DUE TO (c) 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that Dr (this hospital) attended the deceased from January 24, 19 61 to February 7, 19 61 , that Dr (we) last saw the deceased alive on Feb. 7, 19 61 , and that death occurred at 12:35 PM from the causes and on the date stated above.			
22a. SIGNATURE Wendell F. Rosse		22b. DATE SIGNED 2/7/61	
22c. PHYSICIAN'S NAME (Type) Wendell F. Rosse, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) 2/8/1961		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Bairdstown, Georgia		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St. N.W., Wash, D.C.		25a. REC'D BY REGISTRAR FEB 9 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Kline		25c. REGISTRAR'S SIGNATURE	

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